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ABSTRACT

This report describes the Promoting Success in Zero to Three Services Project, which focused on community-wide efforts in six communities to build systems to provide services for families with infants and toddlers. Part 1 analyzes issues confronted by community stakeholders in their 5-year effort to establish, improve, expand, or maintain services integration. Discussion focuses on availability and accessibility of maternal and child health care services and associated public policy implications. Part 1 also includes an overview of the case study process and presents recommendations to public policy makers and community planners. It identifies four critical issues: (1) a shared vision; (2) the complexity of systems development; (3) data access required for services integration; and (4) leadership and support for developing such integrated systems. Part 2 contains a description of each participating community, including a history of the community's system of services for families with young children, an overview of the current system of services, and a discussion of the community's experience in addressing challenges in services integration. These communities were: Fremont County, Colorado; the Lawndale Community, Chicago, Illinois; Scott County, Indiana; Kent County, Rhode Island; Travis County, Texas; and Snohomish County, Washington. Appendices include an article on the National Parent Policy Advisory Group, the study's methodology, and a listing of case study informants. (Contains 31 references.) (DB)

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ZERO TO THREE

National Center for Clinical Infant Programs

Living and Testing the Collaborative Process: A Case Study of Community-Based Services Integration

The Promoting Success in Zero to Three Services Project

EC 303577

Virginia A. View, ACSW
and
Kim J. Amos, MSW

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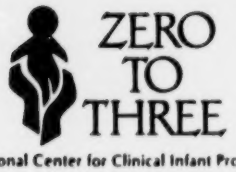

National Center for Clinical Infant Programs

Living and Testing the Collaborative Process: A Case Study of Community-Based Services Integration

The Promoting Success in Zero to Three Services Project

Virginia A. View

Kim J. Amos

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2000 14th Street North, Suite 380, Arlington, Virginia 22201-2500
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ZERO TO THREE/National Center for Clinical Infant Programs is the only national non-profit organization dedicated solely to improving the chances for healthy physical, cognitive and social development of infants, toddlers and their families.

Established in 1977, **ZERO TO THREE** is committed to:

- exercising leadership in developing and communicating a national vision of the importance of the first three years of life and of the importance of early intervention and prevention to healthy growth and development;
- focusing attention on the quality of infants' and toddlers' major relationships and on children's day-to-day experiences within these relationships;
- developing a broader understanding of how services for infants, and their families are best provided; and
- promoting training in keeping with that understanding.

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All other community and state level representatives who assisted us through focus group and individual interviews. A complete list of names is in the Appendix.

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INTRODUCTION

In 1989, the Federal Maternal and Child Health Bureau (MCHB), Services for Children with Special Health Needs Division, and ZERO TO THREE/National Center for Clinical Infant Programs joined to explore possible solutions to a set of concerns shared by both organizations. We recognized that:

1. The early identification of the special health care needs of infants is often difficult to accomplish.

2. An unacceptably high percentage of infants is at risk for poor health and developmental outcomes. Moreover, many infants face multiple biological and environmental risks to healthy development.

3. Policy makers at all levels of government feel constrained by economic realities to choose between immediate needs for treatment and investment in long-term prevention approaches. Prevention approaches tend to be deferred, even though they are likely to be cost-effective in the long run.

4. Despite demonstrations of success in services integration, the development of comprehensive and coordinated service delivery systems at the community level remains problematic.

5. Even when prevention programs are in place in a community, they are not necessarily linked to early intervention initiatives.

6. While there is growing recognition of the importance of family-centered care, this approach is not yet a reality in most systems of care. Professionals are not sufficiently sensitized, nor are systems planned around family needs.

7. The formal pre-service training received by most infancy professionals leaves significant gaps in the knowledge, skills, and sensitivities needed for effective practice with infants and toddlers with special health needs and their families.

Both national policies and community-based service systems are required to address the needs of our youngest children. The MCHB Services for Children with Special Health Needs Division has a tradition of promoting comprehensive, coordinated, family-centered, culturally competent, community-based services. Both MCHB and ZERO TO THREE recognized the need for examples of approaches that effectively provide within communities all the health, education, and social supports required by infants, toddlers and their families. In addition, strategies were needed for promoting access to services for all children who need them, for better collaboration among service providers, and for a healthy partnership between families and the provider system.

In response to these shared concerns, the Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs provided funds to ZERO TO THREE/NCCIP (Grant No. MCJ-115041) to become a national resource center for infants and toddlers with special health care needs and their families. One of the objectives of *The National Resource Center for Infants and Toddlers with Special Health Care Needs and Their Families: "Promoting Success in Zero To Three Services"* is to identify, describe, foster and promote the successes of six community systems that have developed workable approaches into comprehensive systems of care. The case study approach was selected to achieve this objective.

Since 1989, when the case study began, reports issued by The National Commission On Children, *Speaking of Kids: A National Survey of Children and Parents* (1991) and the Carnegie Task Force on Meeting the Needs of Young Children, *Starting Points*, (1994) confirm the timeliness of the concerns that are the basis for the case study. The Carnegie report noted, for example, "that there are no clearly defined institutions such as schools that serve children under age three and that services and supports are not designed in an integrated fashion." These reports suggest an urgent need to promote community-based strategies for linkage and collaboration among services for families with young children, and to help communities to sustain and expand their successes. While the Promoting Success study focused on services for families with infants and toddlers, study findings have relevance for community-based services for all families with young children, birth through school age.

Intended use of this report

This report is intended to provide public policy makers at the national, state and community level and planners of community-based services with:

- descriptions of communities that have a history of success in providing coordinated, family-centered services, including examples of specific strategies that produced successful outcomes;
- an analysis of the issues that have emerged as critical ones to address in order to support and sustain community-based efforts to serve families with young children, birth through school age; and
- recommendations for policy supports that will sustain and expand community-based efforts toward services integration for all families with children.

The Promoting Success case study focused on community-wide efforts at system building. The report documents how six communities, identified at the beginning of the study as successful in organizing comprehensive services for families, have evolved over a five-year period. The report is the result of ongoing contact with a cross-section of community stakeholders. It identifies strategies used to achieve success, and of equal importance, the challenges encountered in communities' attempts to enhance the service system or sustain gains made earlier. This study pays particular

attention to the involvement of parents as key stakeholders in the development of community systems and as key informants about what works and what does not work in efforts to integrate services for families with young children. An article discussing parent involvement is included in Appendix A.

The study also demonstrates the impact of federal and state policy on the way communities organize and provide services. Federal and state categorical funding has been extensively discussed in the early childhood field as a barrier to comprehensive, family-centered service provision. This report describes ways in which categorical funding has affected three specific goals shared by the study communities: 1) making services more nearly universally accessible; 2) linking services into a comprehensive system; and 3) obtaining federal and state support for development of a comprehensive system of services.

Organization of this report

The report contains two sections.

PART I analyzes the issues confronted by community stakeholders in their five-year effort to establish, improve, expand, or maintain services integration. The analysis includes a discussion of the availability/accessibility of maternal and child health care services in the study communities with references to public policy implications. Part I also includes an overview of the case study process (the methodology is described in detail in Appendix B) and a brief description of the communities that participated in the study. This section concludes with recommendations to public policy makers and community planners, and notes and references.

PART II contains a description of each participating community including:

- a history of the development of the community's system of services for families with young children;
- an overview of the current system of services; and
- a discussion of the community's experience in addressing one or more challenges in services integration.

PART I: ANALYSIS AND RECOMMENDATIONS

I. BACKGROUND

The Promoting Success in Zero to Three Services case study occurred during a time in which policy makers and funders, in both the public and private sectors, became interested once again in services integration. This time, however, interest was focused on child and family services integration as a strategy for improving outcomes for children across a range of levels of care and encompassing the full spectrum of child and family needs.

During this period, the Federal Maternal and Child Health Bureau (MCHB) funded state-level Community Integrated Service System Initiatives to reduce infant mortality and improve health outcomes for mothers and children through expansion and development of integrated service systems. The Bureau also funded the National Center for Building Community-Based Service Delivery Systems, one of four MCHB-funded resource centers to provide information and assistance for building service delivery systems that incorporate the concept of family-centered, community-based coordinated care.

In the private sector, the Robert Wood Johnson Foundation and The Annie E. Casey Foundation funded mental health initiatives to improve coordination and develop systems of services for children at risk in 15 sites nation-wide. The United Way's Success by Six campaign funded initiatives to develop integrated service systems for all children in 20 communities nation-wide. The AT&T Foundation funded three community-based services integration efforts, through Project EQUIP, to promote healthy child development and school readiness.

As the Promoting Success study is being completed, language in a number of policy directives and major national legislative proposals speaks to the need for effective coordination of services to families and children in order to achieve desired goals. For example, the Family Preservation and Support Act of 1993 requires family support agencies to collaborate in the development of state plans. The legislation also funds joint training for protective services workers and providers of service for children with special health care needs. The Head Start Expansion Act of 1994 mandates local-level collaboration among early childhood education, child welfare, and special health needs programs; it funds state-level liaison staff in each state who will collaborate with state-level personnel on planning, training and service delivery issues.

But growing interest in services integration has been accompanied by growing recognition of the difficulties in articulating and implementing services integration effectively. The lead article of the National Center for Service Integration's Winter, 1994 newsletter, *NCSI News*, asks, "Providing Comprehensive Integrated Services for Children and Families: Why Is It So Hard?" Linda McCart's *Changing Systems for Children and Families* (1994) explores the challenges in developing integrated community-based services for families with children. Among the "policy and resource

barriers and technical challenges" that "states and localities are facing in implementing a more rational system of services," McCart identifies categorical funding of services, and the numerous - and often conflicting - administrative requirements that accompany categorical funding patterns as the major obstacles to collaboration and services integration at the community level.

More recently, one of the most ambitiously conceived efforts to support services integration, The Pew Charitable Trusts' Children's Initiative, was terminated during its planning phase. Both state-level and community-level interviewees in Rhode Island, one of the states in this study and one of the Pew Initiative states, described the difficulties of reconfiguring state resources and policies in order to meet the guidelines and achieve the outcome expectations for the Pew project.

Clearly, the field is still struggling with the questions, "How do we make collaboration/services integration happen? Where do we start? How do we sustain success?" The experiences of communities that have been "living and testing" the process of collaboration over time may provide answers to these questions.

Since the Promoting Success case study began, other reports on community-based services integration efforts have been developed. They include:

- a study of 18 community-based service integration initiatives by Mathtech, Inc. and Policy Studies Associates (1992). This study examined "preventive as well as crisis-oriented" school-linked programs that offered education, health and social services, for families;[1]

- a study of efforts in four communities to develop and sustain school-linked integrated services, conducted by the School-Linked Integrated Services Study Group convened by the U.S. Departments of Education and Health and Human Services (1993);[2] and

- a study of 14 communities in the Communities Can Campaign, jointly funded by the U.S. Public Health Service, MCHB, and the American Academy of Pediatrics (1993), which examines community-based efforts to establish a system of care for children with special health care needs and their families.[3]

Findings from the Promoting Success case study support the analysis of the McCart report. Our findings also confirm the possibilities of success described in the three other community studies. However, our study indicates that even communities that manage to cope with the challenge of categorical funding face additional challenges as they work to **sustain** the successes they have achieved. These new challenges seem to confront even communities that are experiencing some success in their efforts as they follow the guidelines suggested in the literature on collaboration.

The following pages explore these challenges as well as the strategies that some communities have found useful in confronting them. This section includes:

- a description of our case study process;
- brief profiles of the six communities involved in the study (detailed descriptions of each community are presented in Part II of the report);
- a discussion of issues that emerged as critical for the study communities as they attempted to provide comprehensive, coordinated, family-oriented services to families with young children. The discussion includes an illustration of how maternal and child health care services are accessed in the study communities and the implications for public policy; and
- recommendations for policy makers at the national, state, and local level and for community planners, based on the experiences of the six study communities.

II. THE CASE STUDY: PROCESS AND PREMISES

Beginning in 1989, the Maternal and Child Health Bureau funded the Promoting Success case study to "identify, foster, describe and promote six community systems that use preventive approaches with success so that they can be adapted or replicated nationally." The study was designed with the understanding that much more is understood about exemplary programs than about the integration of a variety of programs into a system of services that addresses the needs of an entire community. Therefore, we wanted to identify communities that were already demonstrating some success in linking prevention and early intervention services community-wide. Then we wanted to chart the evolution of these communities' service systems over the years of the case study, documenting the systems' responses to emerging challenges and opportunities.

Our definitions of the terms "community," "service system," and "services integration" reflect common usage in the literature on services integration:

- **community:** a neighborhood, city, county, or catchment area (not necessarily a political jurisdiction).
- **service system:** a network of direct service programs and provider agencies that are linked, through formal or informal agreements, in order to improve service delivery to a particular target population and/or within a particular geographic area.
- **services integration:** coordination of services needed by a target population across levels of care, with ease of access by consumers as a primary goal of the coordination, which occurs at both the administrative and service delivery levels. Services integration for women in the childbearing years and families with young children is typically conceptualized as linking family planning services; prenatal

and perinatal health care; child health promotion, disease prevention, screening, monitoring, diagnosis and treatment; parent education and support; early intervention, including habilitation, special education, and care coordination; early care and education; and social services, including income maintenance, child welfare services, and other supports.

The case study team (project staff and advisory committee) were interested in the attributes and strategies that characterize promising community-wide efforts. The team developed a set of six such characteristics and used these as criteria for soliciting nominations for study communities and for selecting the communities that would be invited to participate. We looked for communities with service systems for families with young children which were characterized by:

1. **Universal access to services:** A range of services, which can be accessed at multiple times and points of entry, is offered to all infants and toddlers in the community, without regard to preliminary diagnosis.

2. **Inclusive (mainstreamed), non-categorical settings for services:** Infants and toddlers with disabilities or at-risk for developmental problems are served with their typically-developing peers in a well-developed primary health care system and in other family service settings such as child care facilities, family drop-in centers, and neighborhood play groups.

3. **Professional development opportunities for staff:** Programs in the community provide staff with a variety of training opportunities, as well as opportunities for sharing expertise, networking and collegial support.

4. **Commitment to family involvement in service planning and delivery:** Programs work systematically to use parents' expertise in planning and implementing prevention approaches. Programs involve parents as advisors or paid staff as part of the ongoing program.

5. **Linkages across a range of levels of care and service system needs:** The community has a system for coordinating primary, secondary, and tertiary levels of service--i.e., health promotion, prevention, screening, monitoring, diagnosis and treatment are available in some form. Services designed to prevent poor developmental outcomes for children are connected to include prenatal, infant development and well child services that are linked to child development and intervention services as appropriate (e.g., special education, habilitation, case management/service coordination).

6. **State-level support and encouragement:** State leadership encourages community initiative and makes a commitment to using the successful experience of one community as a model for others in the state.

We did **not** try to identify "model communities," recognizing that even if such a phenomenon as a model community exists, it cannot be replicated elsewhere. Our purpose, rather, was to identify promising approaches used by communities that are generally recognized as leaders in the provision of comprehensive, community-based, family-oriented, coordinated services to infants, toddlers, and their families.

The case study goals and objectives were announced through a national network of early childhood, family support and child heath advocates. Communities that demonstrated all or some of the criteria cited earlier were encouraged to apply. The selection of community participants was made by the case study team to reflect not only the best examples of service coordination efforts, but also a geographic and demographic diversity that would enhance the usefulness of our analysis. Our agreement with the selected communities was that they would assist us in collecting data through document review (grant applications, program descriptions, annual reports, statistical data), responding to questionnaires, facilitating our site visits to conduct interviews, and participating in an annual meeting with the project advisory committee.

Our entrée to the communities was facilitated by liaison contacts, individuals who were associated with a multi-service agency or coordinating body in each community and who had been identified during the nomination process. These individuals and their agencies were recognized as the primary coordinators of early intervention and family support service providers in their community. They also were acknowledged as the key facilitators, on behalf of families with infants/toddlers, of family access to the larger system of services (health, social services, child care). The liaison contacts represent a mix of public agencies and private/non-profit organizations; their work is supported by federal, state, and foundation funds, with the majority of support coming from a variety of state-administered categorical funding streams.

We collected data by reviewing documents, administering questionnaires to community and state-level respondents, and making three site visits to each study community over a four-year period. During the site visits, project staff conducted extensive interviews with service providers, key community leaders, and parents. (These community informants are referred to in the narrative of this report interchangeably as interviewees, stakeholders and advocates). In addition, staff interviewed state legislators, cabinet officers, agency administrators, and governors' policy advisors in four of the states. In each community approximately 15 parents served as informants through individual interviews, parent focus groups and as participants in the Project's National Parent Policy Advisory Group. A report describing The National Parents Policy Advisory Group and the outcomes of its efforts is included in Appendix A.

Over the course of the case study, community liaisons, all interviewees (local and state-level), and all State Maternal and Child Health Directors had the opportunity

to review material written by project staff, as appropriate. In addition, all drafts of the report have been reviewed by the project advisory committee, and by key community representatives and providers.

III. THE STUDY COMMUNITIES

Part II of this report describes each study community in some detail, offering a demographic profile of the community; an historical overview of the service system; a current picture of the service system; and a discussion of the community's experience with critical issues in the process of establishing, improving, and/or maintaining services integration. The sketches below introduce each community and highlight some of its distinctive features; these are designed to provide a context for discussion of issues that community representatives identified as critical to the initial success and long-term survival of their efforts.

- **Fremont County, Colorado -- Project ECHO (Early Childhood Health/Education Outreach):** Fremont County is a largely rural community with unemployment and family poverty rates which were higher than state and national averages at the time our study began. Efforts to coordinate services for infants and toddlers in the county began in 1976 with a grant from the JFK Child Development program and have evolved into an early childhood services system which currently includes family support, health, and pre-school transition services that are coordinated by the Project ECHO Interagency Coordinating Council. The successful collaboration and linkage approaches used by the early childhood providers in Fremont County have been widely promoted throughout the state of Colorado, particularly in a statewide family support initiative. The Fremont County community provides an example of successful linkage between community-level and state-level systems of services.

- **North Lawndale, Chicago, Illinois -- Family Focus, Lawndale:** When our study began, the North Lawndale neighborhood, a predominantly African-American community in the city of Chicago, was struggling with the challenges presented by high unemployment rates (22.6 percent) and a high rate of births to unmarried teen mothers. Services for families with young children in the community include an array of family support programs offered by Family Focus Lawndale (one of the family support programs operated by Family Focus, Inc. throughout the Chicago metropolitan area), as well as health, social service and pre-school transition services that are coordinated by various community-based planning groups associated with Family Focus Lawndale. The Family Focus Lawndale approach to organizing and linking services for families in the community has been cited as exemplary by Illinois state officials, and the service delivery strategies developed by Family Focus Lawndale have been incorporated into Family Focus, Inc.'s training component, which operates nationally. The North Lawndale community provides an example of how a public/private partnership can serve a community with a high concentration of need.

- **Scott County, Indiana -- The Kids Place facility:** Scott County is a rural, primarily agricultural community that was facing the challenges of high adolescent pregnancy rates and the highest poverty level for the state at the time our study began.

It is the most homogeneous of our six communities, with a population that contains only two percent ethnic minorities. Most services for families with young children in the county are based in the Kids Place facility, which is operated by New Hope Services, a non-profit agency serving developmentally disabled clients and their families. This "one-stop" facility houses the WIC nutrition program and a network of health, child development, and parent support programs. The successful linkage of services in Scott county has resulted in a state agency initiative to replicate the Kids Place approach in several other counties in the state. The manner in which the Scott County community organized to establish its network of services demonstrates a successful "bottoms-up" approach to systems development.

• **Kent County, Rhode Island -- The Family Outreach Program in Kent County:** This largely suburban community had a tradition of stable employment and broad health care coverage and had been selected by the state to serve as a model for a universal system of comprehensive services for infants and toddlers when our study began. Sudden and severe economic reversals and political changes at the state level halted the initiative for universal services, depressed the local economy, and strained the health and family support resources that were already in place. Community-level providers and parent advocates joined in efforts to maintain the gains they had made and to re-establish support at the state level. The current early childhood system contains a network of family support and early intervention and health services provided by public agencies and coordinated by the County Interagency Review Council. As a result of the Council's success in sustaining and expanding collaborative efforts, the county's approach to service delivery is again being used as a model by the state.

• **Travis County, Texas -- CEDEN Family Resource Center**: This community is largely urban, with 80 percent of its population residing in Austin, the state capital. Travis County is also the most ethnically diverse of the six study communities. When our study began, East Austin, where the non-English-speaking Hispanic population is concentrated, had the county's highest rates of unemployment and teen pregnancy. The CEDEN Center was established in the late 1970's to address the unmet family support and child development needs of East Austin. Over time, Center services expanded to include early intervention programs, and CEDEN became recognized as the primary coordinator of health and early childhood services for the Hispanic population in that community. Travis County's current system of early childhood services includes a network of health, child care, early intervention and family support services that are serving as the basis of The Austin Project, a comprehensive services plan that has been developed for the city.

• **Snohomish County, Washington -- The Birth to Six Planning Project:** This large, primarily suburban county immediately north of Seattle also contains a few small towns, a rural area, and Indian reservations. The county's population includes a mix of ethnic groups and income levels. When our study began, the county was experiencing rapid population growth and stable employment. At that time the county enjoyed a reputation for high-quality services for children and families and strong connections to and support from state-level leaders. Its well-established system of services included public agencies and private/non-profit programs for family support,

health care, and early intervention/pre-school services, all funded by an array of categorical funding streams and coordinated by several planning bodies. During the course of the study, changes in state political leadership and state-wide economic reversals severely strained the capacity of local-level planning bodies and providers to keep the system together. The experiences of Snohomish County demonstrate the impact of state-level and state-wide influences on a system that is heavily dependent upon public funding for support.

IV. CRITICAL ISSUES

During the course of the five-year Promoting Success study, community participants and the case study team recognized that the six service system attributes that had been used as criteria for selecting communities to participate in the study remained significant factors in communities' experiences but, for a variety of reasons, did not remain the major focus of community activity or concern. What emerged instead are four issues that community representatives say must be addressed in order to support and sustain successful community-based services integration efforts. These issues are:

1. the importance of a common set of values and expectations concerning services integration among national, state-level, and community-level stakeholders;

2. the complexity of systems development at the community level;

3. the need for adequate data to plan and evaluate community-level services integration; and

4. leadership and support, at national, state, and local levels, for communities' efforts to develop integrated systems of services.

Exploring the dimensions of these issues, as reflected in the experiences of six diverse communities over five years, has helped us to answer the question, "Why is services integration so hard?" The insights gained by parents, community representatives, state-level informants, and project staff also suggest ways to support communities as they continue the struggle "to get it right."

1. A shared vision: A common set of values and expectations concerning services for families with young children

Community service providers, parents, and other stakeholders in all of the six study communities want their efforts to create a comprehensive, integrated system of services for families with young children to be guided by a vision that is shared by state and federal policy makers. However, these interviewees do not see a national consensus on what a comprehensive system of services for families with young children should include. They do not see a national consensus on the population of children and families to be served -- all children in the community? children with

special health care needs or developmental delays? children at risk of poor outcomes? They observe that federal and state agencies themselves do not model linkage or collaboration or provide sufficient resources to facilitate the process.

Shared visions at the community level

A review of some communities' experiences with articulating a shared vision of child and family services may help us understand interviewees' challenges to state and national policy makers.

In Fremont County, Colorado, service coordination efforts for infants and toddlers began when an institution outside the community sought local sites willing to participate in a pilot project to coordinate services for young children with handicapping conditions, and a group of early childhood advocates in the county responded positively. The group became formalized as Project ECHO (Early Childhood Health/Education Outreach). Its mission was to: 1) promote public awareness of the need for and availability of developmental screening; 2) develop a screening process; 3) create a more in-depth evaluation for those children identified by the screening as having potential problems; and 4) coordinate a variety of services to address the problem.

Even after project funding ended, the council stayed together. Indeed, a long search for funding strengthened linkages and reinforced the shared vision that had developed over the years and led the council, in the words of one member, "to think in terms of a service delivery **system.**" When the availability of state funds allowed the council to redefine its mission and policies, the council decided that it "would not assume the role of an agency but (would) plan, promote, evaluate, support, and coordinate community-based services."

Reaching all children in the county, through personal contact with each family, remains the goal of Project ECHO. The extent to which this goal has become a shared vision in the county is reflected in the words of two community interviewees:

The administrator of a social service agency:

> I can send anyone to this program without having to screen them in my head (to meet specific categorical requirements of one program or another). However, some work is still required...to educate people that ECHO service is not just for "poor children" or for children with disabilities; that it is a single point of entry for <u>all</u> children, those who are developing on schedule as well as for those at risk or delayed...

A parent interviewee states:

> This project has educated parents. There gets to be a community attitude. Parents come to expect what things should be like. They should have services; their children **should** be screened.

Scott County, Indiana presents another example of the capacity at the community level to arrive at a shared vision. Local providers and families recognized the need to build on the existing collaboration between the County WIC program and the early intervention services provided by New Hope Services. As they began to define what a more complete system of services for families with young children would be like, they expanded the discussion to include county officials and local businesses. Their community-wide efforts to plan and obtain funding and resources produced the network of services that are now located in the Kids Place facility. Persons that we interviewed confirmed the statement of one parent that "the entire community understands what Kids Place is about and views it with a sense of ownership and pride."

These two illustrations of the process of developing a shared vision of services integration at the community level confirm the experiences of the other communities: that the process takes both time and resources, but it can be done. Community stakeholders state that the larger challenge is matching their vision, which is based on the realities of their "living and testing" collaborative efforts, with what is often presented as the "national" or "state vision."

The need for vertical collaboration

Some community stakeholders seem demoralized and angry about the lack of "vertical collaboration" in the developing of a shared national vision. They cite a greater need for collaboration among local, state-level, regional, and federal providers and advocates, both within and across service sectors and disciplines. Their concerns, expressed by interviewees in most of the study communities, fall into three groups:

1. Concerns that visions, goals and outcome expectations are developed by academicians, researchers, legislators, and federal and state administrators "who are years away from any direct service" and who proceed with "only token representation" from community advocates. They express concern that they don't see the diversity of the families that are served at the community level reflected in national-level planning groups and spokespersons. One interviewee complained that "too often experts will come in and research the community and then appoint themselves as the spokesperson."

2. Concerns that when national leaders promulgate a vision (for example, of a service system that "responds comprehensively to families' and children's needs") they typically do not provide the time or resources necessary to allow the vision to evolve in the communities.

3. Concerns that the intended goals of federal legislation (for example, Head Start, the Early and Periodic Screening, Diagnosis, and Treatment program of Medicaid, and Part H of the Individuals with Disabilities Education Act) are compromised or undermined by state or local legislation, regulations, or administrative interpretations of federal policy.

Interviewees acknowledged the importance of being guided by a vision that is shared by public policy makers and leaders at the federal and state level. However, they also state that the vision that guides their efforts must be developed with more equitable representation and input from the people who are actively engaged in collaborative efforts at the community level, or as one interviewee stated, " people who are living the experience." They feel that participation from families representing a diverse range of ethnic/cultural groups, economic levels, and health and social circumstances will ensure that the vision is truly reflective of their experiences and has connection to achievable goals.

Some interviewees expressed a desire to participate in helping to define language related to outcome expectations for the vision. For example, a comprehensive system of services or a system that "responds comprehensively to families' and children's needs" is frequently cited by policy makers and advocates as an indicator of quality services for families and children. Our case study process revealed a lack of clarity or national consensus on how "comprehensive" is defined and who would be eligible for the services once they are defined. The communities we studied struggle to collaborate in order to provide comprehensive services in the absence of either clear definitions or modeling by federal and state agencies of what successful linkage and collaboration can produce.

Community-level providers say that their efforts are further inhibited by the lack of resources and supports from the federal and state level for community-based collaborative efforts. Their experiences suggest that until "comprehensive" is more clearly defined, and needed federal and state systems and supports are in place, the expectation that communities can build "comprehensive systems of services" is not only premature, but it also has the potential for producing a sense of failure and a questioning of the practicality of this value. When the vision is developed without community-level input and without the time and resources necessary to allow it to evolve, it becomes, to quote one of our interviewees, "just so much words."

One approach to vertical collaboration: Regular contact between community-level stakeholders and state and federal administrators

Interviewees stated that regular contact with community-level service providers and families would help state and federal agency administrators to review and revise policies so that "the vision" remained dynamic and responsive to changing needs at the community level. Participants in the Promoting Success case study had high praise for the strategy the project used to bring community stakeholders, federal agency administrators, and national early childhood leaders together to engage in substantive dialogue during the course of the case study. Over the course of the project, two groups of community representatives -- a national parent group and a group of liaisons -- met annually with a cross-section of federal administrators (Maternal and Child Health Bureau, Surgeon General's Office, and the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services), and early childhood leaders (advocates, researchers and academicians) to discuss their experiences with a wide range of community-based services and their efforts to develop collaborative structures that are family-oriented. These regular meetings

allowed the two community groups to provide substantive feedback to national leaders on the impact of federal policies on service delivery at the community level. The meetings also allowed for the shared exploration -- with community representatives and federal administrators as equals in the discussion -- of the outcomes of their efforts (the successes and the failures) to achieve services integration. Both the community representatives and the public policy makers described these meetings as "informative and enriching."

This series of meetings documents that there exists a pool of individuals at the community level who are quite capable of: 1) combining a sophisticated grasp of the concepts that shape the visions with their experiences at "trying to make the vision work"; and 2) communicating the outcome of their efforts in a way that can truly enrich the body of knowledge on services integration and systems building.

A strategy for policy development

The experiences of these communities suggest that a common set of values based on definitions and expectations growing out of communities' actual experiences can serve as the basis for a shared vision which becomes the basis for public policy. The experiences of these and the other community-based efforts referenced earlier in the report suggest that there are now a sufficient number of community participants to provide a continuous supply of "fresh faces and voices" to the dialogue on enhancing services integration at the community level.

During their meetings with national-level policy makers, the Promoting Success community representatives recommended that the process for achieving services integration should be developed through dialogues similar to those in their group meetings. Their vision of such a process would include: (1) the clarification of terms among policy makers and community stakeholders, as well as across disciplines and service sectors; (2) the development of a consensus on what will be considered as successful outcomes; and (3) the provision of sufficient time and resources to allow for the testing of strategies and the assessment of outcomes.

Our informants at the local and state level indicated that even as we are working on defining the shared vision, more attention must be directed to understanding how collaboration and systems development occur at the community level.

2. The complexity of systems development at the community level

In the course of our extended contact with the six study communities, we found that looking at four factors helped us to understand the complexity of each community's experience in trying to develop a comprehensive system of services for young children and families. These factors are:

- The definition of linkage goals;

- The demands of existing parallel (and sometimes competing) systems which impede their integration into a larger service system;
- The ever-changing "map" of service programs in each community; and
- The stages of system development.

The definition of linkage goals

Interviewees agreed that collaboration and linkage among agencies is not a goal in and of itself, but rather a means to improve access to and quality of services to families and children. In some communities linkage among agencies began through efforts to improve services for individual children. In other communities linkage among agencies began with efforts to use more effectively the resources from categorical funding programs. During the course of the study it became apparent to the participants that defining specific linkage goals can help communities acknowledge the complexity of the task and also recognize their own achievements. Kahn and Kamerman, discussing linkage goals in *Integrating Services Integration: An Overview of Initiatives, Issues, and Possibilities*, (1993) describe two major categories of essential components for services integration: **administrative management** strategies and **case-oriented** strategies. Administrative/management strategies include:

- Interagency agreements;
- Interagency councils or committees;
- Co-location of services;
- Establishment of a single point for intake and assessment;
- Flexible, pooled, or decategorized funding;
- Co-application procedures;
- Coordination or consolidation of programs, budgeting, planning, and administration;
- Establishment of a lead agency in a multi-agency initiative; and
- Comprehensive management information systems.

Case-oriented service delivery strategies include:

- Case management;
- Case conferences or case review panels;
- Individualized child or family case assessments and services plans;
- Case monitoring or outcome monitoring;
- Focus on the family, rather than an individual member, as the treatment or service unit;
- Home visits; and
- Flexible funds or resources at the disposal of the front-line worker.

While none of the study communities have in place all of the strategies cited by Kahn and Kamerman, we found enough similarities to draw comparisons. Our review of the study communities suggests that for three of the communities, Travis

County, Scott County and North Lawndale, the linkages tend to be case-oriented, in that family access to services is closely tied to case manager collaboration and provider capacity to identify funding or resources for services not covered by categorical programs. For Fremont, Snohomish and Kent Counties, the Interagency Councils play a larger role in determining how resources will be linked across programs, which in turn determines families' access to services. There was consensus among all of the providers interviewed that under ideal circumstances both types of linkage should exist in a community. They also concurred that no matter how the linkage process is categorized, it is critical that the collaborators share the same goals as to why they are collaborating and what the outcome will be.

In several of the study communities, we observed a two-step process that led to increased linkage among service programs. First, programs or networks that had traditionally focused their services on children with disabilities increased their efforts to reach a broader range of children and families (with a greater income range and "at-risk" families). As a result, the providers began to encounter a broad range of unmet family needs (for example, housing, parental employment, job training, and literacy training) that compromised parents' ability to focus on their children's developmental needs. Providers' efforts to respond to the needs of the families led to the next step -- increasing contact with an increasing number of service agencies. In some instances, these case-oriented strategies led to an administrative strategy, such as co-location of services.

The concept of "comprehensive services" that project staff presented to the communities at the beginning of the study involved, at a minimum, administrative and/or case-oriented linkage between early intervention or family support/infant development programs (these tended to be the liaison agencies in study communities) and other early childhood programs. We were also interested in the linkages these programs made with the community's health care, social services and education providers. A "comprehensive" system that is responsive to the needs of children "at risk of poor outcomes" would also include linkage with mental health, housing, and training and employment programs. While all of the study communities initially subscribed to this definition of the term "comprehensive," the realities of achieving such linkages proved to be daunting.

Efforts in the study communities to serve homeless families with young children illustrate the process. Parents in Scott County, Indiana who had been homeless described to focus group participants the demoralizing effects of being homeless, its impact on their children, and the lack of institutional resources, like shelters or emergency housing programs, in their rural community. The Family Focus Lawndale network of services in Chicago has always included housing assistance as one of its services, recognizing that until families have a home, parents have a hard time concentrating on child development issues. During the period of the case study, Family Focus Lawndale used foundation funding to link with the local Housing Authority and expand beyond the referral services they were already offering homeless families with infants and toddlers. With the foundation grant they hired a staff person to locate housing and work with landlords and families to facilitate the families' placement into appropriate housing. Although the program was successful, after one

year the services had to be terminated when the grant that supported it ended. The housing service was not supported long enough to either stabilize the linkage between the two programs or to allow the Housing Authority to incorporate the service into its system. The loss of the service added to the frustration of an early childhood program that was attempting to make the services more "comprehensive."

An illustration of a more sustainable approach also comes from the North Lawndale community. There two multi-service agencies, Family Focus Lawndale (FFL) and the Lawndale Christian Health Clinic (LCHC), provide this high-need community with a network of services that are organized around either family support needs (FFL) or health care needs (LCHC). The two distinct "sub-systems" are coordinated under the umbrella of a larger community action program, the West Side Association for Community Action (WACA). The Directors of both agencies participate in WACA Council meetings to prevent overlap or duplication of effort, and each "sub-system" directs its "comprehensive" services according to the primary need of the individual family.

Front-line providers, administrators, and policy analysts seem to agree that success in linking services across service systems depends on good informal relationships among community-level provider agencies. State and federal mandates for collaboration are empty without this foundation of local relationships. For example, all study respondents cited case managers' knowledge of their community and its service system, along with their skills at building and maintaining relationships across programs, as a basic prerequisite to helping families negotiate the maze of categorical services. In addition, however, interviewees in the Promoting Success communities insist that the horizontal linkage at the community level must be connected to a vertical linkage from community to state to national systems. These community stakeholders argue that in order to survive the economic and political challenges that are bound to occur over time, informal linkages among community agencies must be connected to a more formal support system at the state and federal level.

Linkage requires a commitment of time and resources. In some communities, middle managers in service agencies -- those individuals who should have a key role in the service coordination and integration process -- felt a tension between administrative and case-oriented strategies. In high-need communities such as North Lawndale, coordinating the implementation of case-oriented strategies requires so much of middle managers' time that little is left for participation in community-wide planning meetings. As a result, mid-level staff of public and private agencies (such as the Department of Child and Family Services, Lawndale Christian Health Center, and Family Focus Lawndale) have limited contact with each other. In rural communities, where middle managers frequently function as both administrators and service providers and where managers are often responsible for large geographic areas, the requirements for implementing administrative strategies (for example, travel to planning meetings, pursuing grant funding), compete with the requirements for implementing case-oriented strategies. The common refrain of most middle managers interviewed was "too many demands, not enough time."

In several of the communities, administrators of key agencies, especially child welfare/protective services, admitted the need for more participation by staff and administrators in planning and other service improvement collaborative committees. They state that the demands of high caseloads prevent social services staff from participating actively even in the coordinating and planning committees funded by Departments of Child and Family Services.

At the time of our last site visit, a few of the interviewees in some communities were questioning the practicality of their attempts at services integration as well as the communities' ability to sustain some of their current strategies to improve collaboration between agencies. No one was questioning the value of or need for a comprehensive family-oriented system of services or the possibility that, with adequate and appropriate supports, such a system was achievable. Some interviewees were, however, questioning their ability to achieve linkage goals without the right supports in place. The experiences of our study communities suggest that asking communities to provide "comprehensive services" without clearly defining the term or laying out specific intermediate linkage goals (using a conceptual model derived from Kahn and Kamerman, or others) may be too much of a challenge for any community system.

The competing demands of parallel systems

Most of the services that families with young children use are part of established systems of health care, early childhood care and education, and social services. In each of the study communities, those who are working to develop a comprehensive system of services for families with young children must take into account the realities of these existing service systems, each with its own funding source, administrative mandates, system of accountability, and planning body. Sometimes these realities lead service providers into direct competition. As one Head Start director told us, "A lot of agencies have to have the children before they can get the money. Head Start gets the money first, and then we can recruit the children. This can lead to competition for families."

Funding constraints

Patterns of funding **can** foster collaboration, rather than competition, at the community level. In Texas, for example, the state Department of Human Services uses federal Child Care and Development Block Grant (CCDBG) funds to support the Texas Child Care Management System (Texas CCMS), which in turn funds and administers local Child Care Management Systems. As a result, the County CCMS, working with The Austin Child Care Council that was established by city ordinance, has been successful in developing a range of child care initiatives, including a program which targets teen parents and another that provides temporary child care for homeless families. This blending of funds encourages child care services to link with Head Start programs, early intervention programs, and family support programs and allows the child care system to play a key role in the larger system of family-oriented services that is being developed for the community. The CCMS model at the state level and its

linkage to the county-level programs provide an example of vertical collaboration that is producing positive outcomes for families. The CCMS model at the state level and its linkage to the county-level programs provide an example of vertical collaboration that is producing positive outcomes for families.

A tradition of stable funding may encourage some service providers to "protect their turf" at all costs, but may motivate others to engage in linkage efforts. In the six study communities, Head Start offered examples of both patterns. In four of our study communities, interviewees characterized Head Start Directors as strong personalities, identified with and very loyal to the federal Head Start system, and effective in developing linkages in order to coordinate services for the families served by the Head Start program. At the beginning of the study, interviewees in their communities did not see Head Start as a collaborator with other early childhood providers (early intervention or child care), either at the planning level or at the service delivery level. They indicated that in spite of Head Start's age three-to-five focus, there was enough overlap with families served, especially around transition issues, to warrant more collaboration. During the course of the case study, in almost all of the communities we were able to observe a movement toward increased linkage between Head Start and other early childhood programs. In Snohomish County, for example, where the ICC focuses on birth-to-six-year-olds, the stable service linkages between Head Start and its network of service providers are being used to expand mental health services to children in the early intervention system. (Several factors seem to be involved in the increasing linkages between Head Start and other service programs in the study communities; these include encouragement from Federal funding sources, expansion of community planners' concerns from the birth-to-three population to the birth-to-six age group, and, in some communities, the inquiries of Promoting Success project staff.)

Time constraints

Students of services integration routinely describe (and deplore) the administrative requirements that inhibit linkage among categorically-funded community-based service programs. In the six study communities, we found a new problem -- the proliferation of coordinating councils and committees. As the number of coordinating bodies increase, often in response to state/federal requirements for categorical programs, participation becomes more time-consuming. The drain on personnel resources is especially severe in rural communities, where one staff person is likely to perform two or more roles in an agency and consequently may be called upon to serve on many councils and committees. In some communities, each "coordinating" committee has a slightly different focus and is centered around a different core service. Even in the communities where linkages have been firmly established and are working well, respondents complained about "too many meetings." In spite of this proliferation, in Fremont, Kent, and Snohomish Counties the ICC has managed to maintain the role of primary planning body for services for families with young children.

The Family Outreach Program in Kent County, Rhode Island, has had some success in addressing this problem through the collaborative strategies of its Interagency Review Council (the local ICC under Part H) and the Child and

Adolescent Services System Program (CASSP) mental health initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The Interagency Review Council and CASSP have combined their planning bodies and developed a joint mission statement and a set of guiding principles that is being promoted as a model by the state ICC. A state agency representative described this achievement as "a demonstration of moving away from the idealistic principles of collaboration toward a realistic approach to linking services."

Administrators in two study communities have made extra efforts to ensure that staff are able to practice the agency's philosophy of collaboration. In Fremont County, Colorado, child welfare workers are assigned to various service program advisory boards as a part of their regular duties. The agency director states, "We do a better job of providing prevention services because we are active on these various committees." The director models this role for her staff by serving as an active member of the County Interagency Coordinating Committee. In Kent County, Rhode Island, the Visiting Nurses Association (VNA) and the Early Intervention program commit one-half day per week for each staff member to developing and maintaining linkages that include planning group meetings. The VNA maintains this commitment even though the time is not billable to third party payers and costs must be absorbed by the agency.

The changing landscape of services for young children and families

In all six study communities, the "map" of services available to families with young children changed two or three times during the course of the study. In some cases, the changes represented a consolidation of services for families with young children. An example is the Chicago community's incorporation of existing services into the community's new Healthy Moms/Healthy Kids initiative. However, in perhaps an equal number of cases, change meant the loss of a program, typically a demonstration project that failed to obtain permanent funding. These "lost" programs tended to serve families who were not eligible for, or had needs that did not fit the mandates of, traditional, categorically-funded programs. Typically, these programs had been designed with flexibility that enhanced parent access to their services and that encouraged linkage between their workers and staff and administrators of more traditionally funded programs. As programs come and go in communities (due to short-term funding), the service providers who remain must help families who had been served by now-defunct programs negotiate the eligibility requirements of remaining programs, find new resources for referral, establish new linkages, and reconfigure networks.

There was general consensus among community interviewees that changes that produce loss in services inhibit a network's evolution into a system. When a program appears, families begin to count on it and other community providers make a place for it, in their network of resources. When the program ends due to loss of funding (such as the Family Focus Lawndale housing services described earlier), families and providers must seek a replacement. In some cases (again the FFL housing services is an example), programs end before their effectiveness can be fully assessed. In all six communities, informants complained about the time and energy required of

administrators to reconfigure linkages and write grant proposals to replace needed services lost when programs end. They felt that their energies could be better used to solidify the existing linkages, plan for enhanced services, and monitor and evaluate outcomes.

The developmental nature of collaboration

The experiences of the six Promoting Success study communities suggests the need for a model of collaboration that recognizes how various types of linkages evolve over time into systems of services and that recognizes, as well, the factors that sustain systems once they are established. In the literature on systems development services linkages are frequently described as evolving through stages of: 1) cooperation; 2) coordination; and 3) collaboration. For the most part, our study communities saw themselves as having negotiated those stages when they joined the project. However, during the course of the study, the participants began to recognize that often there is no "neat" transition from one stage to another. The Snohomish County liaison observed, "Our community has moved beyond the euphoric (cooperation) phase to a phase in which you realize that there are so many barriers to true collaboration...now we know what we **don't** know regarding systems and collaboration."

The Institute for Educational Leadership publication, *Together We Can* (1993), based on a study of the efforts of four communities to develop school-linked integrated services, describes a five-stage process for developing a "collaborative" -- a network of agency representatives who form partnerships to assess and plan for community service needs -- and offers detailed strategies for negotiating each stage. The stages are:

1. Getting Together (..committing to collaborate...);
2. Building Trust (developing shared vision,...conducting needs assessment...);
3. Developing a Strategic Plan (...service delivery prototype, ...define target outcomes, ...focus on a neighborhood);
4. Taking Action (evaluate progress, ...implement outreach strategy...); and
5. Going to Scale (build community constituency...develop interprofessional training, develop collaborative leaders...)

The experiences of the six Promoting Success communities confirm the IEL conclusion that system building requires strategic planning, time, flexibility, and resources. Their experiences with planning for services can serve as an example.

Planning for comprehensive services

Child and family advocates in most of the study communities recognized the need for interagency planning long before it was mandated by funders of categorical service programs. During the period of the case study, the requirement for interagency planning under Part H of the IDEA and allocation of funding to support the effort

gave new power to the concept. The composition of the planning groups and the process of planning influenced communities' experience significantly.

Who is involved? To understand the process of planning for comprehensive services for families with young children in the study communities and, especially, the extent to which the planning process develops a common set of values and expectations among participants, one must first understand the structure, mission, and composition of community planning groups concerned with the birth-to-three population.

In all of the study communities, planning groups included representatives from public agencies, private, non-profit service providers, parents, and, in some communities, representatives of local foundations and the business community. In the Colorado and Washington communities, Interagency Councils based on the Part H program provide the leadership for planning for services for the birth-to-six population. When the study began, both communities' councils were focusing on services to children ages birth to three. Over the course of the study both communities expanded their focus to be consistent with state ICCs in serving children from birth to six years of age. Community-level providers supported the expansion and did not describe any negative impact on services for birth-to-three year olds. In Kent County, Rhode Island, the Interagency Review Council is the primary planning body for birth-to-three services. As might be expected, given the Part H philosophy, professional participants in these councils come primarily from public agencies, and parent participation and leadership are high.

In all six communities most early childhood services are funded through categorical programs, either through grants to service providers or through contracts and agreements with other categorically-funded programs. However, in the Illinois and Texas communities, planning groups concerned with early childhood are members of larger, more broadly-focused entities (for example, the Community Action Network in Austin, Texas and the Westside Association for Community Action in North Lawndale, Chicago). Since it is these larger entities which establish community funding priorities and/or allocate city and county available resources (appropriated funds, state block grant funds, United Way funds) early childhood advocates must make the case that the needs of families with very young children should be a community priority. Thus for the Texas and Illinois communities, participation by early childhood representatives in the larger planning bodies not only enhances service coordination efforts but can also result in increased funding of services.

How does planning occur? Most of the planning groups meet monthly to assess service needs (sometimes illustrated through presentation of individual cases), discuss strategies for bridging service gaps, and share resources. With the exception of the Austin Child Care Council, most of the early childhood planning bodies do not have a stable pool of funds to allocate for services. However, they do collaborate on grant applications for specific service initiatives, such as the Outreach Project and Well Baby Clinic in Scott County, Indiana and the Passport Child Health Monitoring project in Fremont County, Colorado.

Some interviewees observed little connection between the day-to-day issues being addressed by the local-level coordinating group and what was happening with the state-level Interagency Coordinating Committee. In some of the communities this lack of connection, described as a "lack of vertical collaboration" in our earlier site visits, began to be addressed over time as state agency staff began to attend local-level meetings.

In Scott County, the planning groups associated with the Kids Place system of services have emerged as the nexus for planning for services for families in this community, with a central role in coordinating the planning of providers from the health and social service systems. Initially, the community's grass-roots, "bottoms up" method for planning was inhibited by attempts to merge it with the state's Step Ahead concept for local-level planning. (Step Ahead is a statewide program to develops a comprehensive service delivery system for children birth to age 13.) The size and composition of the original Scott County planning group that worked well for the community were at odds with guidelines developed by the state agency for local Step Ahead Councils. At the time of the case study team's 1993 site visit, negotiations were underway to achieve a compromise that would satisfy local and state advocates.

As mentioned earlier, all of the communities have a philosophy of broad-based community participation in planning and decision-making. However, one issue that was not addressed was how accountability for outcomes would be shared. This may become an issue of increasing sensitivity as demands increase for accountability of publicly-funded agencies for service outcomes. Should the planning process that mandates that provider/planners share decision-making with families and other community advocates also contain guidelines for how responsibility will be shared when things go wrong? This was the question raised by one interviewee, who also suggested that designating shared responsibility for "failures" might lessen turf battles and make provider/planners more receptive to including families and other community advocates in the planning and decision-making process.

Spiraling back

In the study communities, we found examples of the phenomenon described in *Together We Can* (1993) as "spiraling back":

> Collaboratives will often find themselves repeating milestones and stages as new people are engaged and as the group continues to clarify its purpose and intent. This process of "spiraling back" should not be seen as an indication that the collaborative is failing to make progress; indeed it will often be the case that spiraling back is essential for the entire collaborative to move forward with energy and commitment. (page 19)

Several interviewees in the Promoting Success study communities, describing their experiences in services coordination, expressed regret that they had not been better prepared for "how hard it would be and how long it takes" to establish productive linkages among programs. They said that in addition to each stage

requiring more time than originally anticipated, collaborative efforts were vulnerable to being "trapped" in a given stage due to circumstances beyond the control of community-level stakeholders.

Stakeholders in Kent County, Rhode Island and Snohomish County, Washington had to revisit linkage goals and objectives and modify or eliminate planned initiatives when political and economic changes threatened their collaborative systems. Their experiences illustrate the impact of external factors (such as state-level political or economic crises) and state-level support on communities' ability to negotiate the stages of system development and survive challenges to achieved success.

When the Promoting Success study began in 1989, Snohomish and Kent Counties were enjoying the fruits of a history of healthy collaboration among early childhood agencies and strong fiscal and administrative support from state legislators and state agencies. Snohomish County was the beneficiary of several years of planning by the Children's Commission, a large group of professionals who had begun organizing on behalf of improved services to children. County service programs had strong fiscal and political support from the State Department of Social and Health Services and the Department of Education. The county's system of services was perceived by state early childhood leaders as positioned to become a model in the field of prevention and early intervention services for children. By the time of our second site visit to Snohomish County, in 1991, the election of a new Governor, changes in the state legislature, and an economic downturn had resulted in a decrease in financial and political support to the county's child/family services system and to local planning bodies. These events occurred at the same time that categorical programs (such as Part H, which provided little or no money for direct services) had increased mandates and planning bodies associated with the categorical programs had proliferated. When we visited in 1991, County service providers and parents were experiencing lower morale and reporting decreases in the quality of services for children.

When we first visited Rhode Island in 1989, Kent County had developed a network of local and state advocates and agency professionals who were preparing to implement a plan for comprehensive service delivery that was expected to be a model for the state. They had designed a system of services that included universal family outreach, family support, primary health care, early intervention, and pre-school transition services for all infants and toddlers in the county. Over the next two years, Rhode Island experienced economic and political changes that not only postponed the comprehensive services initiative, but also seriously strained what had been a thriving network of local providers, as individual directors scrambled for resources to sustain their own model programs.

By the time of our visits in 1991, Snohomish and Kent County leaders were questioning whether their communities' array of services for families with young children could any longer be called a "system." The liaison for Snohomish county describes them as being "stuck in the planning stage because of fears that categorical funding streams were decreasing ...(causing) people to become protective of their turf."

Over the course of the next two years, key players in both communities worked to maintain the local network of services and to increase state support. In addition, the primary planning bodies in both communities obtained consultation from individuals experienced in interagency collaboration to help in understanding and negotiating the developmental stages of collaboration. By the time of our 1993 site visits, Kent County was successfully modeling some service approaches, such as its neonatal screening program, and Snohomish County was holding its own. The liaison says, "We still struggle with the balancing act of trying to provide high quality services to increasing numbers (of families). The desire is the keep quality high but the temptation is to dilute (quality) and serve more (families). Not an easy issue!"

Planning based on awareness of the developmental nature of systems building

An example of comprehensive planning based on recognition of the developmental nature of systems building is The Austin Project proposal. Described as a "Comprehensive Strategy for Collaborative Economic and Neighborhood Development," the plan was conceptualized and drafted by a cross-section of community stakeholders during 1990-1993, with a detailed version of the plan published in March, 1994. It proposes a comprehensive planning process that will link all health, education and family support services, in both public and private sectors. The design of the plan -- its outcome goals and measures, staffing plan, timeliness and proposed funding strategies -- appears to have taken into account many of the factors that relate to the developmental aspects of system building. The plan contains outcome goals for target populations (perinatal/early childhood; middle childhood; adolescent) as well as system change outcome goals, with specific outcome measures for each service component. The proposed governance plan includes leadership by a Governing Board, a steering committee, and paid and volunteer staff. The twenty-year initiative is designed to begin with a seven-year demonstration in three low-income neighborhoods in East Austin. Proposed funding strategies include reallocation and new allocation of city and county funds and tax revenues, new funding under state and federal discretionary grant programs, and "improved use of federal and state entitlement grant funds through waivers" to enhance linkage of services. The plan is scheduled for implementation beginning in January, 1995.

3. Access to data required for services integration

During the course of the case study, access to the data required to plan for and assess outcomes of services integration emerged as a problem for all six communities. Community-level service providers described conceptual, administrative, and technical problems.

Conceptual issues

Following the practice of similar studies, Promoting Success staff and advisors defined "community" broadly and flexibly (see page 6) as a neighborhood, city, county, or catchment area. From the beginning of the case study, we anticipated that the project communities would differ in terms of geographic boundaries, population densities, and demographic characteristics of populations served. However, this

flexibility made it difficult, and in some cases impossible, to obtain data on the birth-to-three population in the study communities that would aid planners in describing and analyzing the service system for infants, toddlers, and families in their community. For example, data on Medicaid utilization may be aggregated for a state, but not for a county, and certainly not for a neighborhood. Other health statistics were more likely to be available for ages birth to one year (infant mortality data) or birth to 21, but very little useful data on birth-to-three year olds.

Differing definitions of what constitutes a "system" of services affect data collection and analysis. We found that each community's service system was as unique as the community itself. In some cases, the system was organized by representatives of a group of local programs, organizations, and local and state agencies who collaborated to develop a system. In other cases, a single program or facility serves as the central provider, as well as the coordinator of other services in the community for infants, toddlers and their families. In each case the way services are organized and their linkage to each other determine what information is collected, its accessibility, and the possibilities for analysis of data across communities. During the course of the Promoting Success study, as community liaisons became more involved in project staff's examination of their system of services, they themselves began to question how "system" was being defined in their community.

Administrative issues

Differing administrative and reporting mandates for programs that serve young children and families mean that data are not likely to be aggregated or analyzed easily for community-wide planning or assessment. Some service providers observed that the data collection and reporting procedures mandated by funding sources do not serve the information needs of the service programs themselves. They cite this as an example of differences in expectations of state and federal funding sources and local providers regarding "what the services are supposed to be about."

Over the course of the study, community representatives became increasingly aware of the importance of, as well as the difficulties involved in accessing, descriptive and statistical data on service components in their service system. They cited the need for a common numbers base (number of families/children served; types of services utilized) that everyone could access for individual program reports and coordinated planning efforts. Midway through the project, state Maternal and Child Health directors were asked to assist community-level participants/planners in obtaining basic statistical and demographic data. While all who were asked agreed to provide assistance, the results were mixed. Some community leaders were given all the information that was available to state agency staff. Other community planners received very little or no information from these state sources.

Technical problems

Community interviewees identified a need for better technology (e.g., personal computers and fax machines) and for equipment that is "user-friendly" and well

maintained. They also cited a need for technical assistance on more effective analysis and interpretation of the data available to community-level providers.

As they deal with increased expectations regarding comprehensive planning, collaboration/integration of services, and accountability for service outcomes, community providers tell us that they must have more effective access to the data required to respond to these expectations. They describe effective access to adequate data as: 1) the administrative and policy support to collect and use data for planning and assessing service outcomes; 2) community-level participation in defining the purpose and use of data to be collected; and 3) access to information-processing technology and the technical assistance necessary to use that technology well.

4. Leadership and support for developing systems of services for families with young children

Interviewees who are working toward services integration in the six study communities emphasize the need for leadership and support of their efforts within their own communities, and at the state and national level. In their view, such leadership and support for services integration should take the form of enabling legislation, funding, modeling of collaborative strategies among state and national legislators and administrators, and providing incentives and positive reinforcement for successful efforts at services integration.

Community-level support

Who is involved?

Success in community-based services integration is connected to broad-based community support. While service providers have typically led community efforts to build a comprehensive system of services for families with young children, support from parents and others, (for example, the business and religious community) is also important. In at least three of the communities a variety of community stakeholders have provided active interest and support.

In the Chicago Lawndale community, the Westside Community Action Program, Sears Roebuck & Co. and other major employers of community residents, and neighborhood religious leaders collaborated to provide leadership and resources to community residents and service providers who wanted to establish a family resource center that would eventually serve as the center of the network of other services for families and children.

In Scott County, Indiana, service providers, elected officials, and business leaders actively participated from the beginning with community residents in planning, promoting, and raising funds for the Kids Place facility, which is now the center of the network of services for families and children in Scott County.

In Austin, Texas, the CEDEN Family Resource Center was the result of collaboration among corporations based in Austin; community religious groups, which donated space for the program; the University of Texas, which provided technical assistance; and community residents. This initial collaboration served as the basis for subsequent efforts that have expanded the network of services for families with young children throughout Travis County.

Parent participation

In all of the study communities, interviewees cited parent interest and investment as an important factor in sustaining the collaborative efforts of service providers. Although many communities are working toward full partnership between parents and professionals in community planning efforts, the value of even limited parental involvement was acknowledged by interviewees. One provider noted that "the presence of parents as observers keeps us honest." A parent interviewee commented that when parents can observe and benefit from effective linkages among providers on their behalf, "We receive a consistent message that they value our concerns...that they are interested in our well-being".

In the Chicago and Indiana communities, parents take on advisory and planning roles for the development of services, and parents are employed in the programs that serve families with young children. In the Colorado, Washington, and Rhode Island communities, parents chair the local interagency coordinating bodies. In each of the study the communities, however, only a small group of parents participated in an advisory volunteer capacity. Parents that we interviewed complained that "it's usually the same parents over and over" who volunteer. They recommended increased outreach efforts as a solution.

Even in communities in which planning groups provided incentives to parents, such as transportation, child care, and/or stipends to attend meetings, economic and ethnic diversity among parent advisors or volunteers was limited. Liaison agencies that had traditionally served only children with special health care needs or disabilities found it particularly difficult to recruit parents of typically-developing children to participate on advisory committees. Consequently, in all the study communities, parents of children with special health care needs appeared to be the parents most active in community planning. As could be expected, the most pressing concerns of these parents center on the delivery and integration of health care services. Both parent and provider interviewees recognized a need for more diversity among parent advocates and advisors, particularly as efforts are made to develop prevention-oriented systems of services.

Parent involvement in school-based early childhood programs was an issue of concern cited by parents in several communities. Several parents described their child's transition to school-based programs as an experience that made them feel "that the schools are not very family-friendly." Community-level early intervention service providers expressed a desire to have state leadership in promoting "family-oriented" concepts and practices in their community schools so that parents could continue to serve as resources for promoting the child's development.

The potential impact of parent involvement and advocacy is demonstrated by the Parent Network in Kent County, Rhode Island. Although parent involvement in the Family Outreach Program was quite limited at the beginning of our study, by the time of our second site visit a parent advocacy group had been established that had received recognition at the state level. When Rhode Island's economy became depressed, the state legislature voted to cut all early intervention funds from the 1991 budget. The fledgling Family Outreach parent advocacy group organized a campaign that included the local media and parents from other communities to lobby for restoration of the funds to the state budget. They were successful. Those parents have since provided the leadership for the Interagency Review Council and other planning advisory groups in the county.

Leadership development

In all of the study communities, the leadership of individuals was an important contributor to communities' successful efforts at services integration. In each community, our case study liaison was a longstanding advocate for services for children. Typically, the liaison had either been one of the original developers of a key service component in the community or had been one of the community's early advocates for linkage among services. Over the years these individuals have become known in their communities for their skill at pursuing resources and relationships to expand the pool of services for children and families. Local and state interviewees often remarked on these leaders' "staying capacity" -- their ability to build and maintain contacts with private funders and/or key state-level policy makers, in order to obtain results for the community.

As we view the history of individuals' contributions to collaboration efforts, we need to recognize that an ongoing conflict of values between leaders in different spheres can hinder collaborative efforts. Successful collaboration usually involves the pooling or sharing of resources. Yet in bureaucracies, the people who have moved up the career ladder to become local and state agency administrators are often individuals who have been "rewarded" for protecting the agency's resources. They have been conditioned to conserve rather than to share. Even though they subscribe to the concept of collaboration in theory, their "gut level sense" is to protect the resources for which they are accountable. In contrast, key players in our study communities were often known for their ability to convince others of the long-term benefits of pooling resources. Frequently they were able to demonstrate within their own programs the creative mixing of funds from multiple categorical programs and other sources (foundation grants, donations) to expand services to families.

Occasionally a key player was described as "a strong personality whose commitment to his/her own style for getting things done" had hindered the collaborative and linkage process. However, in the study communities where this leadership style was cited as a challenge, other stakeholders appeared to be developing strategies to address the issue, rather than giving up on the collaborative effort. In most cases, the key players were described as individuals who demonstrated flexibility in their dealings with others and a willingness to share credit for successes. In many

cases they seem to operate according to the philosophy of one interviewee, "You can get almost anything accomplished if you let the right people get credit for it".

During our interviews and site visits, we were struck by the extent to which community advocates, parents, and state-level interviewees alike tended to attribute the success of service delivery and coordination in their communities to the efforts and leadership styles of specific individuals. We were concerned enough about the extent to which the success of the efforts appeared to be tied to these individuals that we asked community liaisons and other interviewees about the development of new leaders. In most communities, it did not appear that community stakeholders had directed a great deal of attention or effort to the issue of leadership development. This suggests that as long as working relationships at the service delivery and community planning level are the basis for the continuum of collaboration, linkage, coordination, and ultimately, service integration, factors such as personality and leadership style warrant further examination. One would want to understand the characteristics that community stakeholders believe a good leader should have, as well as environmental circumstances that enhance or inhibit the emergence of leaders or support leadership development. This issue is particularly relevant to the need to identify resources that will support ongoing leadership development at the community level.

State-level leadership and support

Interviewees in all six study communities saw state leadership and support as critical to the success of collaborative efforts. First, state fiscal support is critical to the survival of both service programs and planning efforts at the community level. Second, state policies set administrative guidelines and eligibility criteria for many programs that serve families with young children. In addition to fiscal and administrative supports, community-level interviewees cited the need for leadership and support through improved planning at the state level and through the modeling of collaborative strategies and providing incentives and reinforcements for successful efforts.

Perhaps because the community stakeholders saw their relationship with the state executive, legislative and administrative leaders as critical to their success in providing coordinated, family-oriented services, they were quite vocal in their complaints and cited many examples of what they see as lack of support and the need for improved vertical coordination among state and local agencies and advocates, both within and across service sectors.

State-level planning

All of the states in which study communities are located are undertaking some initiatives designed to improve services for young children and their families. The impetus comes from either federal legislation, such as the Part H program under IDEA, the Governor's office, or a state agency. All of the states have established or are establishing planning and coordinating councils as the first step in the process. This step has usually been followed by design of a comprehensive plan for children's services and, in some states, encouraging the development of local planning bodies

linked to the state's coordinating council. Colorado has established First Impressions, a state Planning Council for early childhood services that sets funding priorities and coordinates all of the state's health, mental health, education, and family support initiatives. It receives funding from the Part H Interagency Coordinating Council and staffing support from the state Head Start Collaboration Grant. In Colorado, Texas, and Indiana, state plans included a comprehensive plan for training in early childhood services and resources to support training. In Washington and Illinois, the "map" of state-level children's commissions and councils appeared to mirror what was happening at the local level regarding numbers of groups, all with differing core services and funding, but with missions that appeared, in several cases, to overlap. Rhode Island, as a participant in the Pew Children's initiative, was in the midst of reorganizing its state plan for children during the period of the case study. In all six states some of the planning groups have representation from the private provider, advocacy and business sectors, but most are composed largely of state agency representatives, from health, human services, education, and, in some cases, recreation, housing, and economic development and employment. Most of the planning groups were described as having a mechanism for parent input, often with parent members representing community-level concerns.

When community-level representatives were questioned regarding their experiences with or expectations of from these state-level planning and coordinating groups, their responses ranged from enthusiasm to cautious optimism to outright cynicism. An interviewee from Snohomish County commented "They (state administrators) are always introducing new dance steps, but expect us to do them to waltz music" (meaning "another new initiative, but no resources or changes in administrative policies to support it."). An interviewee from Indiana stated that two years after the reorganization of his state's agencies he has seen no impact at the local level:

> There were changes in name only, problems such as turf issues still exist...We have no sense of collaboration at the state level because of the high turnover (often due to reorganization or reassignment) among state agency staff...there is no time to learn who they are or establish a relationship.

However, there were examples of positive steps toward improved planning. Illinois' Governor's Problems Resolution Office (PRO) illustrates a promising strategy for state-level planning efforts to enhance service delivery at the community level. The PRO is a partnership between the Governor's Office and Kids PEPP (Public Education and Policy Project). PRO serves as a liaison between community-based programs and the Governor's office to encourage identification of case examples in which specific policies and procedures are barriers to direct access to services or to collaborative efforts at the community level. The expectation is that review of these examples could result in modification of policies or procedures in order to improve service delivery. Family Focus Lawndale has experienced favorable outcomes from their referrals to PRO, and interviewees expressed optimism that the program will have a positive impact on the state early childhood systems by focusing attention on barriers to full service for families.

Modeling collaboration

A third step, following the establishment of a state-level planning body and the development of a plan for serving families with young children, involves modeling the implementation of collaborative strategies.

In Illinois, the Coordinator of the State Part H program described obstacles to collaboration that begin within the state's early childhood system. The two programs that serve infants and toddlers are administered by the Board of Education but in different divisions. She describes the two programs as suffering from "structural and operational separation of early childhood services within the State Board of Education." The Part H program is in the Division of Special Education and the Prevention Initiative is in the Division of Student Development and Early Childhood. Although the program directors meet, share information and review requests for proposals together, because the programs are in different divisions they have separate relationships with all other agencies with whom they share the same constituency. This results in a redundancy of effort on the part of the agencies to whom they relate. Our interviewee describes this as a costly arrangement that also slows down service delivery at the community level. Another interviewee from Illinois cited the need for "informed and committed leadership from the top down regarding the importance of family-oriented services." She said "this won't happen until we get people in the leadership positions who understand the importance of the early years."

Colorado began with collaboration between the Cabinet Council on Families and Children (a group of state agency directors) and the Governor's Commission on Families and Children (a group of private and non-profit service providers, business representatives, child advocates, parents, and private funders which was created to advise the Governor and the Cabinet Council on policies and issues that affect children and their families). The Governor's office provided substantive leadership and political support to both the Commission and the Council, which eventually merged into **First Impressions** - The Governor's Early Childhood Initiative. First Impressions is chaired by Ms. Bea Romer, the wife of the Governor and an advocate for children's services with a national as well as statewide reputation. This planning and coordinating council has pooled new and existing private and public funds to establish eight Family Resource Centers around the state, one of which is now the home for the Project ECHO system of services in Fremont County. The Fremont County representatives are enthusiastic about the success of the initiative there and are optimistic about its success throughout the state. The design of the state Family Resource Center Plan and the blended funding that supports it can be traced, in part, to the active lobbying over the years by Fremont County early childhood advocates and providers. They describe an ongoing relationship with state agency staff and the Governor's staff in which they regularly responded to information queries, sought consultation from state agency staff, testified at hearings and before the state legislature, and kept state level contacts abreast of local level developments, both negative and positive. The vertical collaboration that emerged resulted in local-level advocates having significant input into the design of a Family Resource Center Initiative that is reflective of a vision shared by state and community stakeholders.

Texas provides two examples of modeling state-level collaboration. Linkage and collaboration resulted in the Texas Early Childhood Intervention (ECI) program, which was established by state legislation in 1981 and became the lead agency for the IDEA Part H program. The Child Care Management System (CCMS), established by the Texas Department of Human Services in response to federal welfare reform legislation, allows local contracting agencies using eight different funding sources to work with eligible families and child care providers to optimize continuity in subsidized child care.

Mixed messages from state agencies

Several interviewees expressed concern about what they feel is lack of state-level encouragement and/or mixed messages regarding the effort they invest in making the system work on behalf of families.

Advocates in several communities described stress that resulted from apparent inconsistency or arbitrariness in state support of community-level collaboration. In Indiana, for example, the Governor, state legislature, and state agencies acknowledged and publicized Scott County's success in co-locating services in the Kids Place facility. But when an initiative to replicate these strategies elsewhere in the state was planned, underlying conflicts between the original funding concept for Kids Place and the state's reliance on categorical funding became apparent. During two decades in which services in Scott County had been supported through the Title XX Social Services Block Grant, providers had been able to use funds for both intervention and prevention efforts for children with disabilities and families at risk. Locally, Title XX contracts were supplemented by local tax dollars and foundations to provide a broad base of comprehensive services. This was the context in which Kids Place was developed. More recently, Indiana's state plan for early intervention restricted these funds to children and families meeting specific eligibility criteria. Services for children and families at risk were to be funded through various other programs, including Healthy Families, Family Support and Preservation, Head Start birth-through-two funds, etc. Each of these initiatives has its own eligibility requirements. Scott County interviewees saw the process as creating a fragmented system that is difficult for families to access. The replication effort added, in the words of a county advocate, "a dramatic increase in the paperwork and administrative requirements -- a maze of funding with accompanying regulations, tracking requirements, surveys, etc." Meanwhile the state has not yet addressed longstanding administrative barriers to collaboration that Scott County service providers had identified as a substantial impediment to Kids Place's effectiveness. This inconsistency, in the view of the Scott County administrator, could possibly doom the replication efforts to failure and was most certainly dampening further collaborative efforts in the county.

In another state, the child welfare agency approved the establishment of a community-level program in which protective services workers, early childhood professionals, and parent educators collaborated in training AFDC recipients to become foster parents. At the same time, in keeping with a vision of family-oriented, culturally responsive services, the state agency agreed to modify the foster home selection and licensing process so that it would become more reflective of community

norms and values. Just before the evaluation of the newly-trained prospective foster parents was to take place, however, a network television exposé of problems in family day care (unrelated to the study community or the foster parent training program) apparently made some state officials sufficiently uncomfortable to rescind the modifications in the foster home evaluation process. Consequently, many of the families who had participated in the collaborative training program and had been recommended by staff to become foster parents were disapproved. A community interviewee reported negative effects on two levels. Agency staff who had been involved in and supportive of the collaborative training program and saw it as successful became cynical about the extent to which local and state politics thwarted their efforts; they are now less enthusiastic about other collaborative initiatives. Families who had demonstrated a willingness to improve their own circumstances and offer support to other children in the community also became cynical about agency "motives" and described the "government (as) killing" a successful program that was consistent with the families' own values. The community advocate observed, "It will be more difficult to sell the next 'vision' to this community."

Professional development as an incentive and reward for collaboration

The issue of professional development surfaced repeatedly in community interviewees' discussions of state-level support for community-level collaboration. Professional development opportunities, it will be recalled, constituted one of the attributes the case study team looked for in selecting communities for participation in the study. During the course of the study, however, most communities had to put issues of professional development "on the back burner" while advocates struggled with the demands of obtaining and preserving direct services for families. These advocates recognized, however, that professional development was needed to sustain their successes. They cited opportunities for increased training on best practices, supervision and mentorship, and training about collaboration and system building as worthwhile incentives for their own continued efforts.

Another perspective on the training issue came from an interviewee who complained that state agency administrators "bring in outside consultants to train others with the strategies that we developed." This advocate suggested that, instead, the state should pay community stakeholders to train their counterparts in other communities. Such a strategy would reward successful collaboration and build in-state capacity.

It was a Rhode Island state agency administrator who observed that "not enough attention has been directed to the psychological stress associated with making collaboration work...there are very few incentives/reinforcements for local level advocates, providers and planners to commit the time and energy required to make this stuff work." However, the state of Rhode Island has demonstrated support for the successes of the Kent County Family Outreach system in at least two ways. One was to use the strategies for linkage and collaboration that were developed in Kent County as the model for the State's plan for participation in The Pew Charitable Trusts Fund's Children's Initiative. In addition, the state asked Kent County administrators to implement a statewide neonatal screening program, using the strategies developed by the Family Outreach Program.

National leadership and support

Interviewees in the six communities look for federal support for their accomplishments and for federal leadership in ongoing efforts to achieve systems integration. Interviewees expressed strong sentiment that leadership and support for their efforts must be more visible at the federal level since public funding supports so many of the services they are expected to coordinate. They acknowledged the impact of state laws, regulations and policies on how services are defined and delivered at the community level. However, they stated that the federal leaders have an important role to play in modeling support. Community and state level interviewees expressed concern that there is still too large a gap between the vision of comprehensive, coordinated early childhood services promoted through federal legislation and what is actually modeled by federal legislators and administrators.

Community-level interviewees frequently cite as an example of the gap between vision and practice at the federal level the mandate for collaboration under Part H of the IDEA. In all of the communities, there was high praise for the impact of the philosophy of collaboration that was imbedded in the Part H program. In most of the study communities, the Part H program has served as the prime resource for promoting and supporting collaboration, coordination of services and parent involvement. The Part H program was cited also as an important resource for funding demonstration projects and prevention efforts. Community-level advocates acknowledge the importance of federal funding of technical assistance (through the National Early Childhood Technical Assistance System [NEC*TAS]), to help states establish interagency coordinating councils and otherwise facilitate linkage of services. But community advocates also point out that seven years after passage of P.L. 99-457 and five years after the regulations were issued, the federal agencies that fund and develop policies for early intervention services were still grappling with a federal interagency agreement through the Federal Interagency Coordinating Council (FICC). In a few communities, interviewees feel that they "took the concept (of interagency collaboration) and ran with it" without strong examples of federal and state leadership. They are proud of what they were able to accomplish while they were, as one interviewee commented, "waiting for the feds to get their act together."

Community and state-level advocates are heartened by "steps in the right direction" such as the FICC. However, they emphasize repeatedly the need for resources at the community level to support staffing, professional development and training, consultation, and technical assistance to negotiate the challenges that they have learned to expect as part of the collaborative process. These community leaders state that a commitment of sustained funding support for the vision at the national level will send a strong message to states regarding the importance of modeling, providing funding support, and state policies that enhance collaborative efforts and services integration.

Community and state interviewees believe that the national-level private sector also has a role to play in providing leadership and support to community efforts at services integration. National early childhood researchers and advocates provide leadership by promoting community-based efforts and successes and by formulating

concepts, principles and strategies that can be applied at the community level. Private sector funders, including the Robert Wood Johnson Foundation, The Annie E. Casey Foundation and United Way, have demonstrated support for the concept of services integration through national initiatives. Some of our study communities have at one time or another been participants in these initiatives. (In some cases, when foundation funding ended, community advocates were left to reconfigure the service system until new support was obtained for the foundation-supported service or program. While expressing appreciation for the fiscal support from private sector supporters, these community advocates complained that "there must be a better way for national leaders to collaborate in their efforts to assist states and communities in pulling this off.")

Community liaisons also expressed desire for increased collaboration between national-level, private-sector early childhood leaders and federal executive-branch and Congressional policy makers. They cite their experience with the Promoting Success project advisory committee as an opportunity to observe who the key players are in shaping the national vision and recognize the importance of dialogue among public and private-sector early childhood leaders, with participation from state and community- level representatives.

Another argument for vertical collaboration among state and community advocates is the experience of the case study communities with the National Family Policy Academy, sponsored by the Council of Governors' Policy Advisors, an affiliate of the National Governors Association. Five of the case study states were participants in the two academies held between 1990 and 1992. During our 1993 site visits we questioned all community and state level interviewees about the impact of their state's participation in the academy on service planning and delivery at the community-level. The questions were included in an interview guide that was mailed to each interviewee prior to the site visit to allow them to prepare for the interview. At the state level, one interviewee in Texas, two in Washington, and all of the interviewees in Colorado recognized their state's participation. State-level interviewees in Washington and Colorado were able to describe state-level outcomes of the policy academy participation, naming community-level services that were beneficiaries of the participation. However, none of the interviewees in the other two states and none of the community-level interviewees in any of the five participating states had heard of the initiative. If their states sent representatives to participate in a national dialogue on priorities for serving families, not only did these community advocates not have a voice, they were not even informed of the process or its outcomes.

V. MATERNAL AND CHILD HEALTH CARE SERVICES: IMPLICATIONS FOR PUBLIC POLICY

As this report is being developed, the Congress and state legislatures are exploring new approaches to meeting the health, social and educational needs of the citizens of this country. In many cases the issues that must be addressed to enhance and improve family access to services are the same issues that are being addressed by the communities in our study. The communities' experiences with health care services in particular illustrate challenges that must be recognized and solutions that should be

considered as new health, education, and social welfare legislation is crafted and as regulations, policies and administrative procedures are developed to implement new statutes.

During the years of our case study, health care emerged as the prime example of the challenges faced by communities that wish to provide universally accessible services to families with young children. Adequate and universally accessible health care services are commonly acknowledged as the centerpiece of any community's system of services for families with young children. Health experts and children's advocates agree that a comprehensive health care system for young children should contain a range of services, available through public agencies and the private sector, that includes protection against such environmental risks as lead paint and asbestos, preventive services such as pre-natal/perinatal care, immunizations, primary/well child care, mental health, emergency and acute care services, and specialized services for children with special health care needs. In addition, a high-quality health care system should include: (1) outreach and public education programs that are culturally responsive; and (2) the active participation of health care clinicians in the planning of community-based services.

The absence of an effective maternal and child health care system in this country is reflected in indicators such as the U.S. infant mortality rate, which is higher than that of 19 other nations (with a markedly higher infant mortality rate for infants born in African American families); and in our low immunization rate (as many as 60 percent of all two-year-olds have not received all necessary immunizations to prevent childhood diseases.)[4]

Even though the six communities selected to participate in our case study had been chosen because of their promising approaches to providing comprehensive services to families with infants and toddlers, all of the communities, throughout the period of the study, struggled with the issue of making health care services available to families. A related issue concerned efforts to enlist health care providers as active players in collaborative efforts.

Challenges encountered/strategies employed

Recognizing that health care is the most basic of all services that should be available to families at the community level, early childhood professionals, parents and other key players cited a wide range of examples of obstacles to quality, family-oriented health care services in their communities. Following are some examples of challenges faced by families and strategies used in selected communities to address the challenges.

Challenge: Lack of health care providers, particularly specialists, such as obstetricians and pediatricians, and, more specifically, of specialists who will accept Medicaid patients.

Response: The success of the collaboration between the Kids Place network of services and the County Department of Public Health in Scott County, Indiana, has served as a stimulus to the expansion and reorganization of the public health services in the county and increased collaboration between public and private health care providers. An outcome of this collaboration was a grant from the Maternal and Child Health Bureau (MCHB) to fund a well child clinic, located in the Kids Place facility and administered by the county public health service.

In Travis County, Texas, developers of the CEDEN Family Resource Center linked with Seton East Clinic and The Peoples Community Clinic in the early stages of planning. These two neighborhood health centers, originally staffed by volunteer physicians and nurses, targeted immigrant non-English speaking residents. The collaboration of the three programs was a factor in both clinics' eventual eligibility for city, county, and federal funds. Now, as participants in the Texas Star Health Plan, they offer a full range of pediatric and prevention services to Medicaid-eligible and uninsured low-income families.

Challenge: The under-utilization of publicly funded programs such as EPSDT (Early and Periodic Screening, Diagnosis and Treatment), due in part to problems in referral and provider reimbursement policies and procedures.

Response: In Kent County, Rhode Island, where only 40-50 percent of eligible children were enrolled in the EPSDT program, a new screening form for newborns that will allow for referrals at birth is increasing participation. Fremont County, Colorado, has been able to maximize services to families by combining benefits from the EPSDT, Medicaid and the Head Start Handicapped program through a $500 dollar retainer agreement with the local mental health services provider. The mental health team comes to the Head Start center to observe, conduct evaluations and offer consulting services to any family member on-site. Individual counseling through follow-up office visits are covered through a combination of sliding fees and categorical funding. The contract for the collaborative arrangement has resulted in what the Head Start Director describes as "$1,000 worth of donated mental health services in addition to the $500-worth covered in the contract".

Challenge: Non-financial barriers to families' utilization of health care, particularly preventive care, including communication barriers, transportation problems, and long waits at clinics.

Response: In Snohomish County, Washington, Head Start's linkage with Olympic Mental Health programs through strategic placement of the programs across the hall in the same building has increased access to and utilization of both services by families. The co-location produces informal linkages that support the formal arrangements made by program administrators. Olympic Mental Health is contracted to provide mental health consultation, and both programs are exploring the possibility of joint classrooms.

The Family Outreach Program in Rhode Island and the CEDEN Family Resource Center in Texas have succeeded in developing outreach and service materials that enhance service delivery to immigrant populations who would be excluded from services because of language barriers. Family Outreach has collaborated with a local clinic to develop brochures and service delivery strategies that target a growing Portuguese and Hmong population. CEDEN has developed an array of training and service delivery materials in Spanish, including materials for working with teen parents.

Challenge: Involving physicians as active collaborators in community-based efforts to improve services for families with young children.

Response: The success of the providers in organizing a system of services for families in the Colorado community was cited as a factor in attracting a new pediatrician to the community. This pediatrician has become an active participant in the collaborative planning process as well as a source of an expanded range of health care services.

Federal support to communities

For two of the communities, the presence of Federally Qualified Health Centers (FQHC) is making a significant difference in the availability of health care services and the way they are provided. By 1990 Congress had established and provided funding for the FQHC program in response to increased demands on Community Health Centers from uninsured and underinsured patients that resulted in decreased services for Medicare and Medicaid-eligible patients. The legislation established a set of core services that must be available to Medicare and Medicaid beneficiaries who receive services from a FQHC; the center is reimbursed for these services on a reasonable cost basis. Core services include services from physicians, physician's assistants, nurse practitioners, nurse midwives, clinical psychologists, clinical social workers, home nursing services, and some supplemental services and supplies.

In the Rhode Island and Chicago study communities, existing health clinics became FQHCs. In Rhode Island, the improved Medicaid reimbursement rate and a subsidy from the county resulting from FQHC status has allowed the clinic to hire two additional doctors, one of whom is a family practitioner, and expand pediatric services. The federal mandate that FQHCs have staff trained to certify for Medicaid eligibility (as opposed to simply assisting with the application) has resulted in an increase in families accessing Medicaid services. The clinic in Chicago has been able to hire more staff, expand the range of health services provided (including out-placement of nurses and physicians to other community-based facilities), and develop a range of family resource services that are comparable to those offered by the local family support center.

In all of these communities the improved access to health care services was the result of the collaborative efforts of persons with a commitment to community-based family-oriented services and, for two of the communities, the administrative flexibility

and funding support to FQHC's. And while other examples of approaches may exist, our study of these communities tells us that there is still a significant gap between need and available resources. Even these successful approaches may not survive without an environment that: (1) is responsive to the systems development process at the community level; (2) provides supportive leadership at the national, state and local level; and (3) provides a shared vision and definition of community-based collaboration and services integration as well as the technical resources that support that vision.

VI. RECOMMENDATIONS

This report was developed to provide public policy makers and other advocates of improved service delivery for families and children with an overview of the critical issues identified during the course of our study of six communities. These communities which are experiencing success as they work to establish integrated systems of services for families with young children have identified a need for:

- expansion of the partnership that develops a national vision for services to families;
- appreciation by public policy makers of the complexities of systems development at the community level;
- improved access to data required to plan and evaluate community-level services integration;
- leadership and support, at the national, state and community level for community-based efforts to develop integrated systems of services.

As the issues have been discussed, we have included examples of strategies used by community stakeholders to establish comprehensive, coordinated, family-oriented systems of services. The report promotes the concept of vertical collaboration in the design of a national vision, legislation and policies as well as the planning and delivery of services to families with young children. Our recommendations to public policy makers and community planners are based on an analysis of the critical issues identified and the communities' experiences in trying to create a shared vision of services to families with young children, confronting the complexity of service system development, and seeking leadership and support for collaboration.

Recommendations to national and state-level public policy makers

Promoting Success interviewees' three recommendations to national and state-level public policy makers are designed to help them: 1) establish a process to develop and communicate a shared vision of comprehensive, integrated services for families with young children; 2) support and sustain currently promising community-based efforts to achieve services integration; and 3) provide a solid foundation to support beginning collaborative efforts.

1. **Expand the partnership that develops the vision and its expected outcomes.**

   a. Model the concept of vertical collaboration in the development of a shared vision by including state-level and community-level service providers and parents in the decision-making functions of national forums, advisory groups, and planning bodies.

   b. Expand the economic, cultural, and ethnic diversity of the national-level partnership of early childhood advocates. Include representation for culture-specific advocacy groups. Include families with typically and atypically-developing children.

   c. Press Congressional, Federal executive branch, and national early childhood/family support leaders to specify definitions, goals, and measures of success as they develop a vision of services for families with infants and young children.

   d. Use the expanded partnership to develop:

      - Legislation, regulations and policies that reflect lessons learned from community-level efforts already underway.
      - Definitions of critical concepts that are shared across levels of government and across service systems.
      - Outcome expectations and accountability measures for services to families that are appropriate given the resources available.

2. **Demonstrate leadership and support for services integration.**

   a. Model and promote effective collaboration strategies.

      - Communicate the strategies used to create integrated funding streams, effective interagency working groups, and public/private partnerships at the national and state level.
      - Work with community-level stakeholders to document the positive impact on services to families of state-level collaborative initiatives. Describe and promote the strategies used to achieve these outcomes.

   b. Provide support to community-based efforts.

      - Encourage communities to integrate service systems in manageable increments -- starting with one or two neighborhoods, with programs within a service system, or with services to a specific population.
      - Set timelines that recognize and prepare for the predictable challenges of each stage of system development, and that allow for modification based on ongoing assessment and evaluation.

- Establish processes for regular and timely review of national and state-level policies and procedures that are identified as obstacles to services integration at the community level. Build in mechanisms to address case-specific circumstances as well as a process for analyzing and negotiating conflicts across systems or jurisdictions.

c. Provide sufficient resources to support the vision.

- Build funding for case-oriented and administrative service coordination activities into program personnel budgets.
- Support appropriate staffing costs of community-level coordinating and planning entities.
- Fund training and technical assistance to enable communities to understand and negotiate successfully the developmental stages of system development.
- Provide technical assistance to communities for needs assessments and planning.

d. Fund resources to improve quality of data and increase community-level access to data necessary for planning, implementing and evaluating service outcomes.

- Involve community stakeholders in the process of linking data collection to desired family and community outcomes and in establishing guidelines for the use of data.
- Ensure community-level input into the design of information systems that will reflect changing needs and resources at the community level.
- Provide "user-friendly" technology to community stakeholders and the funding to keep it maintained, operational and updated as data needs change.

e. Provide reinforcement and tangible support for successes.

- Recognize successful community-based strategies in state-level communications and encourage the replication of these strategies.
- Increase the number and diversity of successful community-based advocates, providers, parents, and organizations who are invited to serve as state-level speakers and advisors and who are recommended for national recognition.
- Use individuals who have been involved in successful community-level collaborative efforts as paid trainer/consultants in replication efforts. Reimburse exemplary programs and systems for the staff time and resources required to respond to outside requests for site visits and technical assistance.

3. **Integrate the vision and supportive resources into federal and state legislation, regulations, and policies.**

   a. Increase outreach efforts to ensure community-level representation in legislative roundtables and public hearings where legislation and regulations are being drafted.

   b. Designate funding to ensure parent participation in meetings and hearings on national and state legislation.

   c. Fund national advocacy organizations to develop procedures to facilitate review and comment on proposed legislation and regulations by community-level **provider** and **parent** constituents.

   d. Schedule legislative and policy roundtables in conjunction with early childhood and family support-related state and national conferences that community-based planners/providers are likely to attend. Recruit, support and mentor participants who will bring a diverse and community-based perspective to roundtable discussions.

Recommendations to community planners and policy makers

The recommendations for community planners are meant to complement those found in other studies of community-based efforts that we have referenced in this report. The three recommendations are intended to assist community planners in their efforts to: 1) participate in shaping the national vision and outcome expectations for improved services to families with young children; 2) influence the development of public policy that impacts service delivery at the community level; 3) establish effective linkages with state and national leaders in order to increase support for community-based services integration efforts; and 4) sustain and enhance their achievements at the community level.

1. **Seek out opportunities to communicate community concerns and successes to a national audience.**

   a. Submit comments on proposed federal regulations announced in the *Federal Register*.

   b. Share your community's experiences through formal presentations, program showcases, and dissemination of materials at national conferences and meetings.

   c. Volunteer personally or nominate other community advocates to represent your state or region in national workshops on issues affecting families and children.

d. Submit articles about your community's successful strategies or issues of concern to professional, advocacy, and other publications with a national readership.

2. Contribute to state policy development.

a. Maintain a visible presence with your state political and government leaders. Keep them well informed of your progress and success with families. Provide state-level policy makers with feedback and specific examples of both positive and negative impact of state policies on service outcomes for families.

b. Submit written comments on state plans for services to families and children.

c. Provide policy makers with timely and accurate qualitative and quantitative information in written materials about your program and community.

d. Contribute information to statewide assessment and planning efforts (raw data, family surveys, etc.)

e. Attend public hearings on child and family issues and submit written recommendations, including action plans.

f. Invite state leaders to speak at special community events, especially those recognizing achievement.

g. Volunteer and nominate key community advocates to participate in statewide work groups and planning/decision-making committees.

h. Encourage families to organize to advocate for improved services with local and state political leadership.

i. Be prepared for the time it takes to see outcomes from state-level linkages.

3. Identify and address critical issues in the process of developing community-based services integration.

a. Involve all potential community stakeholders in developing consensus on the vision, goals and objectives, and outcome expectations for integration of services to families with young children in your community. Remember that collaboration, coordination, and service integration are processes or means to an end, not goals in themselves.

b. Establish policies and procedures to encourage shared leadership in developing the system of services for your community. Establish a system for leadership development that will:

- reflect the value system and needs of the community.
- identify, encourage and support emerging leaders.
- include parents in leadership development activities.
- increase outreach efforts to ensure that parents from all income groups, ethnic/cultural groups and parents of both typically and atypically developing children are participants in planning and decision-making activities.

c. Acknowledge and prepare for the developmental nature of collaboration and systems development.

- Become familiar with studies and reports of other community-based services integration/coordination efforts. (See the Notes and References of this report.)
- Define linkage goals realistically. Recognize the existence of (and sometimes competing) administrative demands from the various funding sources that support components of a community's service system.
- Prepare for the amount of staff time required for regular meetings and staying abreast of issues that affect various service sectors in the system.
- Prepare for the time required to see significant progress.
- Start with achievable objectives and promote successful outcomes of your linkage efforts in order to sustain commitment to the collaborative effort.
- Seek funding to support technical assistance and consultation to negotiate difficult stages in the systems development process.

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PART II: COMMUNITY DESCRIPTIONS

From the beginning of the Promoting Success study, our flexible definition of community and our desire to study communities with diverse demographic profiles meant that participating communities would differ in terms of geographic size, population density, and demographic characteristics of populations served. We also anticipated differing definitions of a "system" of services. Indeed, we found that each community's service system was as unique as the community itself. In some cases, the system had been organized by representatives of a group of local programs, organizations and local and state agencies who collaborated to develop a system. In other cases, a single program or facility serves as the central provider as well as the coordinator of services in the community for infants/toddlers and their families. The description of each participating community reflects this individuality.

The case study also revealed common experiences, themes, and issues that have relevance for broader application in developing public policy and planning strategies to support community-based services integration. Communities' common experiences can be categorized into two groups:

- those that relate primarily to the original six criteria for selecting communities to participate; and

- critical issues identified during the study as essential for communities to address in order to support and sustain successful community-based services integration efforts.

We discovered that four of the six selection criteria, while remaining significant factors in communities' experiences, for a variety of reasons did not remain the major focus of community activity or concern during the study period. These criteria were universal access, inclusive settings for services, professional development, and commitment to family support and leadership. The two remaining selection criteria -- linkages across systems of care and state support and encouragement -- commanded attention throughout the project period. However, as the project continued, community representatives and the case study team began to understand these criteria somewhat differently. As we learned to recognize the complexity of systems development at the community level, we came to appreciate:1) the importance of shared visions, expectations, and definitions in creating and maintaining linkages across systems of care; and 2) the developmental stages involved in creating and maintaining linkages. During the five years of the case study, we also came to appreciate that "state support and encouragement" is hardly a simple matter, but rather a complex phenomenon in continuing interaction with local and national circumstances and, in addition, very much tied to issues of leadership.

Part I of this report draws extensively on community experiences to support the analysis presented. Part II includes more detailed descriptions of the participating communities, including their experiences related to the six selection criteria. As noted above, linkage and state support issues common to the study communities have been addressed in Part I. In this section, common themes related to the four other selection criteria are discussed.

Universal access to services

At the outset of Promoting Success in Zero to Three Services, all six communities shared a goal of providing universal access to intervention services for all children determined to be at risk of poor outcomes. (Access to comprehensive services for **all** infants and toddlers in the community was seen as an ideal to be pursued, but unlikely to be achieved). Although two of the six communities have made developmental screening universally available, all of the communities have experienced difficulties in serving their target populations because of problems related to multiple funding streams and regulations governing categorical programs.

All six Promoting Success communities work hard to make prevention and intervention services as accessible to families as resources will allow. They pay close attention to location, hours of operation, and ethnic/cultural relevance. While transportation in rural areas remains a problem and outreach efforts to traditionally underserved families need strengthening, community representatives view problems with categorical funding streams and state and federal eligibility and administrative requirements as major barriers to families' access to comprehensive community-based services.

Inclusive/non-categorical settings for services

Mainstreaming, as defined by all six study communities, means integrating in a single setting child care/child development and/or intervention services for children who are developing typically and for children with disabilities or special health care needs. Generally, integrated settings for services to infants and toddlers has not been identified as a major problem for these communities. Again, thanks to the Part H philosophy and commitment of resources, there has been significant support to ensure the inclusion of children with disabilities into mainstream services and programs. This suggests that when mainstreaming for infants and toddlers is a community priority, it is unlikely to become a community problem, provided that funding sources outside the community do not interfere with the process.

Professional development and training

All study communities see an ongoing need for training for front-line staff in child development, family assessment, and case management, to allow for upgrading of skills and for staff turnover. Respondents also recognized that agency administrators need training and technical assistance in planning, evaluation, and systems development skills.

Professional development programs, traditionally the most vulnerable component in human service programs, have been adversely affected in the six study communities as resources shrink. During the course of the study, the communities found that professional development, like prevention efforts, had a better chance of survival when it could rely on local resources. However, by the time of the last site visit, some communities were enjoying the results of renewed state-level interest and support for professional development.

Commitment to family support and leadership

All of the communities professed a vision/philosophy that acknowledged the value of family involvement in developing and providing services for children. The histories of the six communities reflected efforts by professionals to consult with families as service systems were being planned and developed. The experiences of parents who participated in the project's National Parent Policy Advisory Group and in the site visit focus groups confirmed that families do respond to a range of outreach strategies designed to increase their involvement in community-based services. Providing concrete supports, such as child care and stipends increased parent involvement in leadership activities in several of the communities.

While some outreach strategies cost money, many require primarily a community commitment to family support and leadership. Most of the Promoting Success communities have been able to increase parent involvement even as they have been struggling with funding issues. This point is significant because of the need to involve more families, locally and at the state-level, in the development of **prevention-oriented** systems of services. Representatives in all six study communities recognize a need for input from families who have been traditionally under-represented in family advocacy and leadership roles, especially families with children who may be at risk of poor developmental outcomes.

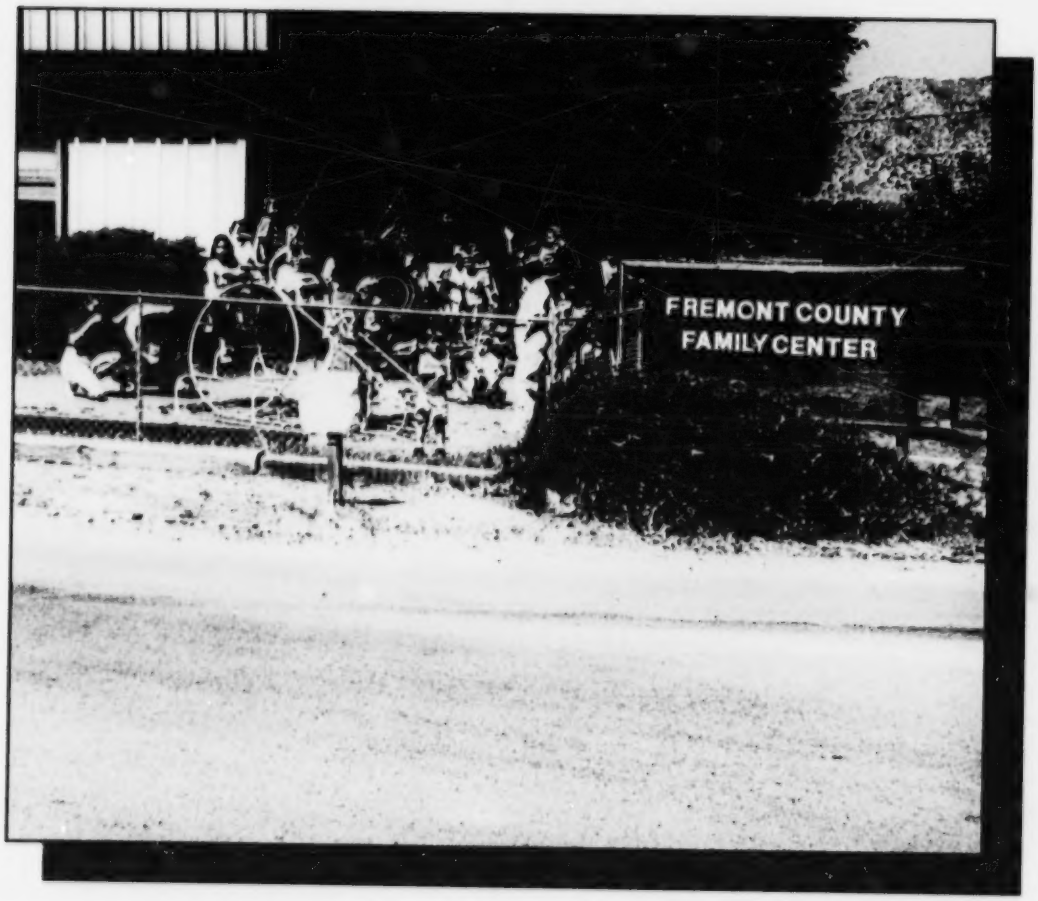
Community descriptions

The descriptions of the six study communities which follow include:

- a demographic profile based on data provided by community liaisons and state agency representatives;
- a brief history of the development of the early childhood system of services;
- a brief description, in text and figures, of the current system of services available to families with young children in the community; and
- a discussion of communities' experiences with critical issues in the process of service system development.

Over the course of the study, all six communities experienced expansion and contraction among resources and programs, sometimes because of reorganization or consolidation, often because of loss of funding. We found the "map" of the service systems in each community continuously evolving, presenting a challenge to our efforts to describe the system and present accurate statistical data. Demographic profiles of communities, and even value systems change as well, although more slowly. Although every effort has been made to be accurate, some information in the community descriptions may no longer be valid. We hope, however, that detailed descriptions will afford insight into the processes that underlie and shape community efforts to improve the lives of young children and families.

FREEMONT COUNTY, COLORADO



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FREMONT COUNTY, COLORADO

DEMOGRAPHIC PROFILE

Fremont County is in south central Colorado, southwest and over the first ridge of mountains from Colorado Springs. The county occupies 1,502 square miles, an area slightly larger than the state of Rhode Island. There is a tremendous sense of open space; one is always within sight of a butte or outcropping of sandstone. Fremont County's three towns, including Canon City (pronounced "Canyon City"), the county seat, lie along the Arkansas River, which runs east-west through the county. At the west end of the county is the Royal Gorge, a dramatic canyon of the Arkansas River visited by tourists and movie companies alike. Vast areas of national forest lie within the county, as well. Fremont is noted for continuing significant discoveries of dinosaur fossils.

The county's 1990 population of 32,273 represented about one percent of the state's population. Almost half of the county's residents live in Canon City; about one-quarter is under the age of 17, and an equal number are over the age of 60. In 1990, Fremont County had 2,142 children under five years old.

More than 85 percent of the county's population is Caucasian, most of whom have lived in the county for a number of generations. The 1990 census recorded a 13 percent minority population in Fremont County, consisting of 8.5 percent Latinos and 4.5 percent Native Americans, Asian Americans, and African Americans.

In 1989, Fremont County's infant mortality rate was 13.7 percent, five points higher than the rate for the state as a whole. In 1990, 16 percent of Fremont County families had incomes at or below the federal poverty level, a rate slightly higher than that of the state and the country as a whole. The county unemployment rate was 8.9 percent, compared to a 5.7 percent rate of unemployment for the state.

In 1991, there were 333 live births in Fremont County. Of those births, 5.1 percent were to teenage mothers, 10-17 years of age. During that same year, the percentage of very low birth weight births was 9.3 for Fremont County, slightly higher than the state as a whole (8.2 percent). The number of families on AFDC -- single mothers and families with an unemployed father -- is increasing.

Decent, affordable housing is a priority need for many Fremont County families, according to a recent study by the Upper Arkansas Area Council of Governments. Waiting time for subsidized housing exceeds two years.

St. Thomas More, Benedictine Health Center is the only hospital in Fremont County. The county has three school districts. The Canon City school system includes five elementary, one middle, and one high school. The Florence/Penrose district has two elementary/middle schools and one high school. The Cotopaxi district has a single school, K through 12.

There are nine state correctional facilities, ranging from minimum- to maximum-security, in Fremont County. In 1990, the Colorado Department of

Corrections -- the largest employer in the county -- employed approximately 1,000 Fremont County residents. A new state correctional facility opened in 1993 and was expected to hire about 200 new employees. A new federal correctional complex scheduled for completion in March, 1994 (on land purchased by the county and donated for the facility) was expected to attract more than 1,600 additional residents to the county for corrections-related employment. These employees will represent approximately one-third of the county's entire work force. Since federal corrections officers must be 35 years old or younger, it is likely that families coming into the community to work at the federal facility will have young children.

Other employers in the county are primarily health and human service agencies; there is a limited manufacturing base. Traditionally low-paying positions for entry and direct-care workers mean that many county families are among the "working poor."

In spite of these economic challenges, many residents are optimistic about the county's future, due in some part to the increased employment opportunities associated with the new correctional facilities. As one interviewee put it, "We all feel this is a good place to raise children. It is close to cities, but it is country. There is a lot of community pride. This is a nice place to live. People work together all across the community to get things" (such as a new Fine Arts Center). As one interviewee stated, "What really matters is relationships."

HISTORICAL OVERVIEW OF THE SERVICE SYSTEM

In 1976, the JFK Child Development Center in Denver, a University Affiliated Facility, sought out local communities which were interested in promoting coordination of services for young children with handicapping conditions. Early childhood advocates in Fremont County volunteered to participate in the initiative. A meeting held to determine the feasibility of the proposed interagency initiative included local representatives from public health, mental health, developmental disabilities, Head Start, preschools, child protective services, the county hospital, private physicians and other specialists, parent and consumer associations, and the local school districts. The group became formalized as Project ECHO (Early Childhood Health/Education Outreach) and subsequently became a permanent Council.

Project ECHO's mission was to: 1) promote public awareness of the need for and availability of screening; 2) develop a screening process; 3) create a more in-depth evaluation for those children identified by the screening as having potential problems; and 4) coordinate a variety of services to address the problem. Funding for the first two years of this pilot project came from the State Developmental Disabilities Council; its third-year funding came from a regional grant through the federal Department of Health, Education and Welfare. A local private service contractor, Developmental Opportunities, served as fiscal agent. A project coordinator was hired by the State Developmental Disability Council in Denver and reported to the Council.

By 1979, when state funds were in danger of drying up, the ECHO Council hired a local coordinator and sought local funding. By 1980, the ECHO Council had turned almost entirely to local sources of funding, receiving funds from United Way,

Fremont Handicapped Persons Society, the local school district, and federally funded Community Services Block Grants.

Over the next several years, the Project ECHO Council members refined policies and procedures, formulated eligibility criteria for the target population, inventoried the resources that existed in the community for serving children and families, and identified gaps in service. They established procedures for matching children and services, maintaining records for program evaluation, and relating to state agencies and interagency committees. They explored ways to improve services and potentially to lower costs through coordination of services.

The Council did not become established quickly or easily. Some county residents saw the Council as a waste of taxpayers' money or expressed resentment that "outsiders" had started it. The initial interagency brokering was time-consuming and hard to accomplish. Some Council members attended erratically. The local hospital representative dropped out of the Council twice. (Yet that member was kept carefully abreast of what was going on and eventually rejoined.) The WIC program was not a very active participant until recently, when the Project ECHO FIRST STEPS program began to collaborate with it to promote breastfeeding. Although Head Start has the local contract to perform EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services for Medicaid-enrolled children, the Head Start program had not participated intensively. However, a core of Council members remained strongly committed through the years to keeping the project alive.

When funds were scarce, the Council had trouble even paying for the coordinator and her secretary. Volunteers and interns were used. Member agencies contributed money sporadically. According to the longtime coordinator:

> As I look back, I wonder what kept us going. Searching for dollars was part of the "glue" that kept us together. Also we had a lot of fun. The families were great and, and the kids got better. We did feel reward for our work. But we couldn't do more than keep our basic child identification program going. Still, no one would let (the project) die till the problems were resolved.

During these years, state and federal agencies provided limited financial support to the Council's collaboration efforts. However, the State Department of Education did sponsor some meetings with consultants who provided advice on interagency collaboration. These contacts helped to maintain enthusiasm for the continuing struggle in Fremont County.

By 1986, the Project ECHO Council had obtained funding to hire outside consultants to evaluate their program. The evaluation confirmed the belief that the county "had something unique," and encouraged the council to apply for federal grants. Although the applications were not funded, the collaboration required to define needs and seek funding strengthened the linkages that had been developed over the years. According to one interviewee, "during this time we began to think in terms of a

service delivery system." An outcome of this process was the development of the Community Integrated Preschool concept; the Colorado Department of Education provided funding to help the Council clarify the systems concept.

In 1987, the implementation of Part H under P.L 99-457 had tremendous, positive impact on the activities of the Council and its staff coordinator. Suddenly Project ECHO's experience was valued statewide. The project coordinator became a member of the State Interagency Coordinating Council's Task Force on Child Identification, a group that met once a month for fifteen months and developed eligibility criteria for Part H services and a statewide Registry for Children with Special Needs. Fremont County became one of four model Child Find sites in the state.

As a result of her Task Force participation, the Project ECHO coordinator brought two other projects back to Fremont County. One was the Partners in Health Care/Denver Child Health Passport Project developed by Dr. William Frankenburg (who also developed the Denver Developmental Screening Test) to promote partnerships between parents and health care providers. The second project was an integrated computerized data management system, which combined information from the Departments of Public Health, Developmental Disabilities (through Developmental Opportunities), and Project ECHO.

In 1989, the Colorado Department of Health began a pilot program to identify children who were at risk for developmental delays or disabilities by creating a registry based on birth certificate information. The Health Department selected 16 Colorado communities, including Fremont County, to implement the Colorado Registry for Children with Special Needs. Each child identified receives a visit from the Public Health Nurse, who discusses early intervention and family services. Many of the children whose names appear on the registry are doing well, but need to have their development monitored throughout the early years. These children are enrolled in the ECHO periodic screening program. Other children are in immediate need of early intervention services. These are referred directly to evaluation through Project ECHO and enrolled in specialized early intervention services.

Colorado Part H funds allowed the Council to engage in further strategic planning, redefining its mission and policies. The Council decided that it would "not assume the role of an agency but will plan, promote, evaluate, support, and coordinate community-based service." The Council has also committed itself to developing a written agreement, to be updated periodically, to specify the levels of cooperation and collaboration among council members.

In 1992, Fremont County established the FIRST STEPS Program under Project ECHO. FIRST STEPS offers family support, parenting and child development information (home visitors are trained in the Parents As Teachers curriculum), and special education services for infants and toddlers.

CURRENT SERVICE SYSTEM

The Project ECHO Interagency Coordinating Council currently coordinates health services, early intervention, family support services, and pre-school transition

services. Funding sources include several divisions of the Colorado Department of Health, the Colorado Department of Education, the state Division for Developmental Disabilities, the Children's Trust Fund, locally administered federal and state grants, local charitable organizations, and local professional institutions and associations. Long-term, consistent funding sources are the Colorado Department of Health (for the ECHO screening program), Community Services Block Grants, United Way, and the Fremont Handicapped Persons Society. However, with the exception of funds for special education services and the salaries of the Project ECHO Coordinator and Deputy Director, all funding is "soft" -- from grants that must be applied for each year, with no guarantee of continuation funds.

The community service system for families with young children in Fremont County is pictured in Figures 1 through 4 at the end of this section. Highlighted below are the county's screening system, which began in 1976; its pilot Family Center; and its FIRST STEPS program.

Screening

As noted above, the initial goals of the Project ECHO Interagency Council were to identify children with delays in development and locate resources to meet the needs of these children and their families. To provide easy access to services for families, ECHO was planned as a single point of entry into the service system for families who have children with developmental delays or disabilities.

The program encourages all families to take advantage of the screenings. All screening and evaluation services are offered to parents at no charge. Personal invitations and reminder calls by ECHO staff increase attendance. Transportation and in-home assessments can be provided to accommodate individual family needs.

Some children with apparent problems, or whose parents have specific concerns, may skip developmental screening and be scheduled for evaluation. Parents always have the choice of screening or evaluation if they have specific concerns.

Monthly screening clinics are held at the Fremont County Family Center, at area child care and preschool centers, and at outreach sites in rural areas of the county. Paraprofessionals are trained and paid by the Colorado Department of Health to administer the screenings. Three of the original screeners continue to work in the program.

ECHO acts as an information and referral service for many generic services. At screening clinics, project personnel inform families about encourage them to take advantage of a variety of community services including child health conferences, immunization clinics, Lamaze classes, prenatal clinics, EPSDT screening exams and referrals, WIC programs, the high school alternative education program for teens with infants, and the program for children with special health care needs. Each of these agencies, in turn, assists parents in making connections with ECHO. It has been estimated that 95 percent of the children referred for early services come from the ECHO screening system.

A Project ECHO database records demographic information, results of screening, results of referrals, and next contact date for each child. The database makes it possible to keep track of more than 1500 children and to recall them periodically for screening or re-check visits.

The Family Center

The Family Center is a community interagency effort funded by an implementation grant from the Office of the Governor that combines funds from the Governor's Job Training Offices; Education, Social Services; and Health Departments; and the Division of Criminal Justice. The Fremont County Center is one of eight pilot sites in the state, chosen perhaps because of its history of interagency collaboration in serving a "working poor" population.

The Family Center is being organized as a "one-stop" service center. The Center houses Project ECHO early childhood services, including FIRST STEPS services, ECHO screening and evaluation clinics, infant/toddler special education, and service coordination. The Family Center began to offer child care services for children 2 1/2 years old and older in May, 1993. A parenting and community resource center is housed at the Center. Services provided on a part-time basis at the Family Center include WIC, EPSDT, GED and literacy programs, financial counseling, mental health counseling, and alcohol and drug abuse counseling.

A five-member coordinating committee directs Family Center activities. The committee includes the ECHO Director and a salaried parent coordinator.

FIRST STEPS

Located in the Family Center, FIRST STEPS offers family play groups, parenting workshops, a Warm Line information service, breastfeeding support, and car seat and equipment lending. In addition, home visitors trained in the Parents As Teachers curriculum provide monthly home visits and resource coordination to parents who desire these services.

Services for infants and toddlers with special education needs now come under the FIRST STEPS umbrella. No child is ever denied services or placed on a waiting list. The program acknowledges the differences in families by adapting the full range of FIRST STEPS services to meet the unique needs of each child and family. For example, parents of children with special needs may choose to have home visitors come weekly instead of monthly. Their home visitor may be an occupational or speech/language therapist, certified by Parents As Teachers. Alternatively, FIRST STEPS Home Visitors may consult with an early childhood special educator to adapt the Parents As Teachers Curriculum to meet a child's needs. Play groups at the Family Center are facilitated by the FIRST STEPS Activities Coordinator and the Infant/Toddler Supervisor, who is an occupational therapist. Many activities are designed to meet a wide range of developmental needs, so that each child can participate at his or her level. Special educators also develop or adapt lesson plans for the play groups, based on the individual needs of participating children.

Through its Home Visitors, FIRST STEPS also issues to parents of all newborns in the county, at no cost, a parent-held child health record called The Passport. The passport booklet becomes a record of a child's health during the first six years. It includes information about the child's growth, development, and family history. It lists the examinations, tests, and immunizations the child needs at each scheduled health supervision visit.

Each visit is recorded on a triplicate form. The parent supplies information about nutrition, health and development. The examining physician completes the remainder of the form. This design encourages the parent and health provider to talk about concerns each might have noted. After the visit, the provider sends a copy to the passport program coordinator for computer data entry and keeps a second copy for the patient's medical chart; the third copy remains in the passport. A computerized database records demographic information about families and their utilization of health services. The ECHO coordinator can keep track of the health care services each child in the county receives. Physicians receive monthly printouts to inform them of missed visits or missed procedures (for example, immunizations or health education) among their patients. Home visitors follow up with a telephone call or home visit to families who miss important health care services.

"Refrigerator pages" accompany each well-child visit sheet. These pages contain anticipatory guidance about health, development, nutrition, and safety, which the physician has discussed with the parent. Once the parent returns home from the health visit, he or she tears out the page and fastens it on the refrigerator door with a magnet that is provided with the passport. In addition to reminding the parent of important information, the "refrigerator page" also lists the date and time of the next health visit appointment.

Home visitors from FIRST STEPS contact each family of a newborn to make certain they know how to use the passport. Visitors remind parents by telephone of scheduled health visits for the first four months and by postcard for the remainder of the first year.

HEAD START

In addition to case management and family support services for families with infant/ toddlers who are siblings to 3-5 year olds enrolled in Head Start, the program also provides administrative case management to all children in the county who are enrolled in Medicaid. During the past two years, Head Start has made a priority of providing EPSDT services to 0-3 year olds.

COMMUNITY SELECTION CRITERIA AS REFLECTED IN FREMONT COUNTY

Universal access to services

The stated goal of Project ECHO is to have personal contact with each family in order to reach <u>all</u> children in the county. The Passport program and the county's developmental screening programs are the chief means of reaching this goal. The

Passport Coordinator of the First Steps program contacts every mother of a newborn. Screening is done free of charge in a central location, with flexible hours, and with transportation provided for those who need it. Outreach clinics are held once or twice a year at two other sites in the county. Project ECHO and the County Health Department screen approximately 45 percent of all children in the county.

Much more than in most communities, Fremont County families have come to see Project ECHO screening as a non-threatening, non-stigmatizing service for all families. The administrator of a social service agency in the county says, "I can send anyone to this program without having to screen them (for eligibility) in my head. However, some work is still required even with Council members to educate people that ECHO service is not just for 'poor children' or for children with disabilities; that it is a single point of entry for (all) children, those who are developing on schedule as well as those at risk or delayed..."

Fremont County also works to ensure full utilization of programs which have eligibility requirements. For example, the Fremont County Nursing Service, operating on the principle of presumptive eligibility for Medicaid, provides an emergency card that allows a baby to be seen quickly. EPSDT case managers are assigned to a variety of community programs, (Head Start, the Family Center, Developmental Evaluation clinics) to ensure that eligible families receive services.

The establishment of the FIRST STEPS Program and the Family Center has succeeded in making comprehensive services more widely available to families with young children. FIRST STEPS takes newsletters to mental health and well child clinics, child welfare agencies, WIC, the Lamaze groups, the day care association, and the resource and referral center. The wife of the City Administrator is a participant in the program, as is the wife of one of the town's leading lawyers. Thus, though the program provides home visits to high-risk families, its center-based activities are becoming perceived as a service for all. (Currently, most parents participating in the Family Center are high school graduates. Parents who are college graduates typically have their own play groups, and the Family Center tends not to reach parents with less than a ninth grade education, although FIRST STEPS does offer group meetings for teen parents in the two county high schools.) FIRST STEP undoubtedly misses families from the old coal camps and other impoverished rural areas of the county -- the same families that the screening program has difficulty reaching.

The parents interviewed in Fremont County generally credit Project ECHO with facilitating their access to needed services. They gave Medicaid high marks for making emergency care accessible, but complained about attitudes of some private physicians and dentists toward Medicaid patients -- for example, refusing to see Medicaid patients again if they miss one appointment. The pediatrician who runs the Developmental Evaluation Clinic, however, views Medicaid positively and also notes that "Project ECHO works to get coverage for things not covered by Medicaid."

The Director of Project ECHO recognizes the need for more services and for easier access by families in Fremont County. She notes several challenges:

- Specialized early intervention services for infants and toddlers with special needs are limited.

- More resources are required to meet families' needs for housing, employment, mental health care, and substance abuse treatment.

- Most service programs are targeted to specific populations or are not "family friendly"; consequently, care coordination and advocacy on behalf of families require a great deal of knowledge and time.

- Income eligibility guidelines, by definition, limit universal access to services. More specifically, guidelines which differ from program to program limit impede both access by families and linkage among services. Providers observe, in addition, that some programs' eligibility guidelines place families in an "on again, off again" status that makes it difficult, if not impossible, to establish and maintain the supports families need.

- The unmet needs of low-income working families present a special challenge to service providers in publicly-funded agencies. These families do not have health insurance but are ineligible for Medicaid. They do not qualify for child care subsidies. One interviewee noted, "Many of (these families) are better off on welfare -- but pride keeps them off."

- The concept of one-stop shopping meets resistance from some program administrators, who want employees under their own roof in order to better supervise them. In understaffed service systems, administrators are reluctant to assign staff to a central facility.

Inclusive, non-categorical settings for services

In Fremont County, services can be home- or center-based, as families prefer. Center-based programs for infants and toddlers are all integrated, serving typically and atypically developing children. Parents involved in FIRST STEPS home visiting may choose either a FIRST STEPS home visitor or an early childhood special educator who is trained in the Parents as Teachers program. Transportation is provided for families. Categorical funding remains an obstacle to serving all families. A dearth of infant/family child care options also limits opportunities for inclusion.

Professional development opportunities

In general, Fremont County interviewees reported a lack of professional development opportunities for providers of early childhood services, although they appreciated consultation and technical assistance that has been provided by state agencies. They spoke of the need for a continuum of training opportunities which would include easy access for beginning or entry-level staff who are not professionally trained, an early childhood BA program, and resources for continuing education for front-line providers.

Interviewees note that new service initiatives are bringing with them opportunities for training not only in the skills involved in working directly with children and families, but also in collaboration itself. These opportunities include:

- *Training and technical assistance for Family Centers*: Ongoing technical assistance will be provided bi-monthly to local sites through the state-level Family Center Council. Community-level staff will be trained in the Parents as First Teachers curriculum, intensive training designed to sensitize providers to work with parents in order to create a system of working with and involving families.

- *An Annie E. Casey Foundation grant to First Impressions*: This grant will provide for cross-agency staff training in collaboration and the development of a curriculum for training community-based family advocates.

- *A statewide network for family support agencies*: Similar in purpose to the national Family Resource Coalition, but not a part of it, the network will offer symposia and other professional development opportunities.

Commitment to family support and leadership

According to one Fremont County interviewee, whose comments were typical of many others, "This project (ECHO) has educated parents. There gets to be a community attitude. Parents come to expect what things should be like. They should have services; their children should be screened." As one parent put it:

> I'm very impressed with the way this town takes care of its people. It's amazing to me they do it. Where I come from they don't do it. Like free shots. And I never heard of coming to your home and visiting with your kids. My sister wishes she had services where she lives. For awhile I felt all on my own. But I found there's a lot of people out there to help. If you can't get to them, they'll come get you.

Another respondent observed, however, that this level of parent involvement might be possible only in a small community, where the communications systems are informal and where parents and professionals are talking to each other.

Parents are involved in many roles in addition to that of program participant. For example:

- Parents participate and have leadership responsibilities on the Parents Advisory Committee for First Steps, the Family Support Service Committee, the Family Center Council, and the Colorado Department of Education Advisory Council on the Care and Education of Young Children.

- Parents helped to draft the grant proposal for the Family Center.

- Parents are employed as Parent Advocates at the Developmental & Evaluation Clinic, as Home Visitors for FIRST STEPS, and as staff in the Head Start program.

The FIRST STEPS program recruits parent educators, most of whom are parents themselves, from a broad spectrum of the community. Its Parent Advisory Council includes a woman in recovery from an addiction, a teenage mother with ambitions of becoming a high school science teacher, a Latino mother who had been in a similar program elsewhere, a public health nurse, a grandmother (who has custody of her grandchild), and a lawyer who is a Kiwanis chapter member. The Parent Advisory Council has been credited with giving very solid guidance to FIRST STEP's Project Director and staff on programming and special projects.

Fremont County parents in a focus group convened by the case study staff said that they are exploring ways to address two challenges:

- Involving fathers -- "Hunter Safety" classes and Father's Day activities are being planned for the Family Center.

- Involving a larger group of parents -- focus group participants observed that "the same parents participate over and over."

CRITICAL ISSUES REFLECTED IN FREMONT COUNTY

Linkages across a range of levels of care and service system needs

Fremont County interviewees agree that the ECHO Council is key to the county's success in linking and integrating services for infants, toddlers, and their families. More specifically, it is the active participation on the Council of Directors and decision makers from key community agencies that results in linkages such as the following:

- The Director of the Developmental Evaluation Clinic (a pediatrician) serves on the WIC Breastfeeding Task Force, and WIC workers are assigned periodically to the clinic.

- Head Start donates the use of its buses for the monthly immunization clinics operated by the county public health department.

- Head Start collaborates with the County Nurses Association on referrals for EPSDT.

- A contract between the West Central Mental Health Clinic and Head Start has brought a psychologist on-site at the Head Start facility, reducing the stigma attached to mental health counseling.

- Administrators of the Fremont County child welfare agency report that their participation on the interagency council helps them use their limited prevention resources more effectively.

The process of planning and establishing the Fremont County Family Center expanded collaboration among service programs and systems. For the first time, the county Head Start Director and a Head Start Parent were key players on an interagency planning team. Members of the ECHO Council serve on the Family Center Council as well. The Family Center is being organized as a "one stop" service center, housing both full-time core early childhood programs and, on a part-time basis, programs including WIC, EPSDT, immunization clinics, a GED and literacy program, Joint Training and Partnership Act and other jobs programs, a food bank, library story hours, and mental health and substance abuse counseling. Application for a range of public assistance programs can be made at the Family Center.

The development of the Even Start program in Fremont County illustrates how linkage works here. Even Start is a federally-funded (Department of Education) program to help support parents with a child under school age who are working toward their GED (General Education Diploma). Many of the parents have children under three years of age. Parents enroll in one of three programs: English as a Second Language, Basic Skills, or GED. The Fremont County Library, Head Start, and the Department of Social Services provide adult literacy experiences for the parents. In addition, parents attend a Parent Club once a week, either in the morning or evening. Lunch or dinner is served; special celebrations are also scheduled, usually around holidays. Transportation is provided. While parents are learning about child development and parenting, children have their own "play and learn" times. The last 40 minutes of each three-hour session are spent in a parent/child play group, where parents can practice some of the things they learned in the Parent Club.

Even Start funding and staffing patterns reflect the pattern in which services develop and are integrated in Canon City. The Canon City School District is the fiscal agent for Even Start. The district contracts with Developmental Opportunities to supply employees. Because Developmental Opportunities is the fiscal agent for all Project ECHO grants and therefore the official employer of many infant/family workers, the Even Start employees are individuals who were already working part-time in other capacities. For example, the Passport Program Coordinator now also serves as the Even Start Coordinator. The woman who facilitates the play groups at the Family Center now also facilitates the Even Start Play and Learn time for children and the Play Group for parents and children. As an interviewee noted, "People (in Canon City) were several hats and their positions are funded by several programs. I know this sounds confusing, but it works."

State support and encouragement

Evidence of state-level support and encouragement for services integration can be seen in the planning bodies and resources which interviewees identified as dedicated to improving collaboration at the state and local level.

Planning bodies

- **First Impressions** (The Governor's Early Childhood Initiative) receives funding from the Part H Interagency Coordinating Council, and staffing support from the state Head Start Collaboration Grant. The Governor's wife, Ms. Bea Romer, who has a history in Colorado as an advocate for children's services, serves as chair. First Impressions has been successful in pooling private and public funds to establish eight Family Resource Centers around the state, one of which is now the home for the Project ECHO system of services in Fremont County.

- The **State Efforts Group** meets monthly to plan the sharing of funds to improve early childhood services and is seen as able to influence what happens at the community level. The group is composed of state agency middle managers.

Other state-level interagency groups include the State Interagency Coordinating Committee for Part H, IDEA, the Colorado Department of Education Advisory Council on the Care and Education of Young Children, the State Committee for Head Start Collaboration, and the Statewide Immunization Coalition.

Resources

State-supported resources that facilitate services integration include:

- **The Family Centers Initiative**: Eight model comprehensive services facilities are described above. Grant requirements provide incentives for community-level collaboration.

- **COTRACK**: An automated data management system, funded initially through a federal grant administered by the Colorado Department of Health, is designed ultimately to create a data base that can be shared and accessed by the various state agencies.

- **Colorado Resource and Referral Agencies**: Telephone referral services for families, funded by the Child Care and Development Block Grant, are primarily for child care but also for other services. Health information is provided through linkage to health agencies.

- **State Department of Education, Part H**: State and county-level coordinators, paid through Part H funding, support collaborative efforts, including state and local Interagency Coordinating Councils.

It is worth noting that all community-level interviewees believed that the high level of state support for collaborative efforts enjoyed by Fremont County is directly tied to the networking efforts of the Director of Project ECHO. In the words of one respondent, "The state agencies tend to spend money on people that they know, so a lot depends on the relationships established."

Interviewees cited three areas in which state support could be improved:

- Early childhood services should be conceptualized as serving children 0-5 rather than 3-5.
- Communities with a history of successful collaboration should be rewarded, through funding for expanded or enhanced services or grants to provide technical assistance to other communities in the state.
- Conflicting administrative requirements (many originating in federal statutes or regulations) remain a barrier to services integration.

COMMUNITY SYSTEM FOR FAMILIES WITH YOUNG CHILDREN
FREMONT COUNTY, COLORADO

STATE PLANNING BODIES AND RESOURCES

EARLY CHILDHOOD SERVICES SYSTEM

FAMILY SUPPORT

- The Family Center
  - First Steps Program
- Even Start
- County Dept of Social Svcs
  - Medicaid Kid Care
  - Baby Care
- Family Support thru Developmental Disabilities

HEALTH-CENTERED

- Fremont County Nursing Svcs
- Developmental Screening
- Developmental Evaluation Clinic
- Child Health Passport
- Registry for Children with Special Needs
- WIC Nutrition Program

PRE-SCHOOL\TRANSITION

- Fremont County Pre-School
- SPIN - Special Needs Pre-School
- Head Start

COMPREHENSIVE POLICY AND PLANNING BODIES
- ECHO Council
- Family Center Council

- Health Services
  - St. Thomas More Hospital
  - West Central Mental Health
  - Fremont County Nursing Service
  - Private Providers

School Districts
Canon City Schools
RE 1; RE 2 & RE 3

Fremont County Society for the Handicapped

Council of Governments
- Head Start
- WIC
- JTPA

Fremont County
Dept of Social Services
- Child Protective Svcs
- Child Welfare

Drug and Alcohol Abuse Inc
(County Level)
Chemical Abuse Steering Team
(CAST)

Developmental Opportunities

Child Care/Preschools

FREMONT COUNTY DEMOGRAPHIC PROFILE

TOTAL POPULATION	STATE	COMMUNITY
• total population	3,294,394	32,273
• African-American	4 %	3 %
• American Indian	< 1 %	< 1 %
• Asian	2 %	< 1 %
• Caucasian	80 %	87 %
• Latino	13 %	8.5 %
• Other	< 1 %	< 1 %
• below poverty level	11.1 %	16.1 %
• unemployed	5.7 %	8.9 %
• Medicaid recipients	unavailable	10.2 %
• WIC recipients	unavailable	5.2 %
• high school grads	79.9 %	83.8 %
• Live births - all Ages	15.9 %	10.4 %
• Live births maternal age <18 years	13.1 %	10.3 %
• Low birth weight	8.2 %	unavailable
• Infant mortality (1989)	8.7/1000	13.7/1000

LOCAL SERVICE SYSTEM PROFILE	LIAISON PROGRAM	COMMUNITY SERVICE SYSTEM
• total 0-3 served	211	659
• of 0-3 served, % poverty level	67 %	57 %
• total direct service staff	42	unavailable
• bilingual staff & sign language	42	unavailable
• total ethnic minority staff	4	unavailable
• total staff live in community	39	unavailable

The information presented here represents data from 1990 and 1991, except where otherwise indicated. See Appendix B: Community Case Study Issues for discussion of accessibility of statistical data and its implications for service planning and delivery.

Figure 2

Chart I	Major Funding Source	Universal Access 0-3	Ease of Access	Cultural Inclusive	Center or Home Base	# Indiv Served 1990	Referal Follow up	Training Type	Training Hours	Staff Turnover	Parent Involvmnt	Eval.
Prenatal Health Svcs.	d	no	a,f	a,c	center	unavail	yes	a,c	unavail	85%	f	a,c,d,e
Perinatal Svcs.	d	no	a,f	a,c	center	unavail	yes	a,c	unavail	25%	f	a,c,d,e
Teen Preg. Prog.	not	available	in	*	community	*	*	*	*	*	*	*
Childbirth Educ.	a	yes	a,f	a	center	unavail	yes	c	unavail	100%	unavail	unavail
WIC Program	e	no	a,f	a	center	unavail	yes	a	b	not often	a,b,f	d,e
Head Start	e	no	a,b,d,e,f, g,h	a,b,c	both	60	yes	a,b,c	c	5%	a,b,c,d,e,f	a,b,c,d,e,f, g
Primary Hlth. Care	a	no	a,f	a,c	center	unavail	yes	a,c	unavail	25%	f	a,c,d,e
Immunization	d	yes	f,a	a	center	unavail	yes	a,c	unavail	0%	f	a,c,d,e
Parenting Instruction	d	yes	h	a,b,c,d	both	unavail	yes	a,b,c	c,d	10%	c,e,f,g	a,b
High Risk Registry	d	yes	n/a	a,b,c,d	n/a	unavail	yes	a	a	n/a	d,e	c,e
Inf./Tod.Dev. Screening	b,c,d	yes	h	a,b,c,d	center	658.92	yes	a	a	0%	d,e	a,d
Tracking System	b,c,d	yes	n/a	a,b,c,d	n/a	658.92	yes	c	b	n/a	d,e	a
Child Care	a	no	unavail	unavail	home	unavail	yes	a	unavail	unavail	d,e	unvail
Early Intervention Infants	d	no^	h	a,b,c,d	both	20	yes	a,b,c	d	0%	a,c,d,e	a,d,e
Toddlers	d	no^	h	same	both	unavail	yes	a,b,c	d	0%	a,c,d,e	a,d,e

KEY

Major Funding Source

a private
b public: local
c public: county
d public: state
e federal
f client fees
g 3rd party
h other

Ease of Access

a central geographical location
b flexible hours of service
c accessible to public transportation
d transportation provided for the disabled
e transportation universally provided
f bilingual staff (including for hearing impaired)
g wheelchair accessible
h waiting lists monitored and updated
j other

Cultural Inclusiveness

a population served is culturally and/or economically reflective of the population in need of services
b public awareness campaigns target diverse groups
c staff reflect the diversity of the population serviced
d use culturally appropriate/sensitive assessment tools

Training Type

a content that focuses on assessing children, working with individuals or families
b content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c other (specify)

Training Hours

a 8-20 hours
b 20-40 hours
c 40-80 hours
d 80 + hours

Parent Involvement

a as member of child's staffing team
b in support groups
c in parenting classes
d on advisory committees
e as board member
f as staff
g other

Evaluation

a self administered
b parent agency administered
c county administered
d state administered
e federal
f all of the above
g other_____specify
h parents are a part of the evaluation team

n/a = not applicable *not available in community

unavail = unavailable ^ = limited to infants who meet state qualifications

Figure 3

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Chart II	Major Funding Source	Universal Access	Recruitment Enrollment Type	Services Offered	Ease of Access	# Indiv. Served 1990	Referral w/ Followup	Family Needs Assessment	Indiv. Svcs.	Group Svcs.	Support Groups	Cultural Inclusive	Training Type	Training Hours
GED Classes	c,d,e	yes	a,b,c,d	a,b,c	a,c,d,e,f,g,h	52+	yes	no	no	yes	yes	a,b,c	a,b	a,b
Employment Counseling & Placement	e	unavail	b,c,d	a,b,c	a,c,e,f,g	1432	yes	yes	yes	yes	yes	a	a,b,c	b
Housing Assistance	d,e,c	no	a,b	a,c	a,b,h	150	no	no	no	no	no	d	c	b
Financial Assistance (Medicaid; AFDC; SSI)	d,f,h,g	yes	a,b,c,d	a,b,c,d	a,b,f,g,h,i	632	yes	yes	no	no	no	a,b,c	a,b,c	c
Mental Health Evaluation & Referral	e,d	unavail	a,b,d	a,b,c	a,b,c,g	698	yes	yes	yes	yes	yes	a,b,d	a,b,c	b,c
Substance Abuse Treatment	d	yes	a,b,c,d	a,b,c,d	a,b,c,f,g	327+	yes	no	yes	yes	yes	a,b,c	a,b,c	d
Child Abuse Prevention & Detection Program	d,e	unavail	a,b,c	a,b,c,d	a,b,c,f,g,i if needed	125+	yes	yes	yes	yes	yes	a,b,c,d	a,b,c	a,c

KEY

Major Funding Source

a	private	e	federal
b	public:local	f	client participant fees
c	public county	g	3rd party payment
d	public state	h	other

Recruitment/Enrollment Type

a	self referral
b	referrals from other programs
c	outreach from this program
d	other

Services Offered

a	Direct services
b	Screening/assessment
c	Referral for other services
d	Other

Ease of Access

a	Central geographical location
b	Flexible hours of service
c	Accessible to public transportation
d	Transportation provided for the disabled
e	Transportation universally provided
f	Bilingual staff (including for hearing impaired)
g	Wheelchair accessible
h	Waiting lists monitored and updated
i	Other

Cultural Inclusiveness

a	population served in culturally and or economically reflective of the population in need of services
b	public awareness campaigns target diverse groups
c	staff reflect the diversity of the population serviced
d	use culturally appropriate/sensitive assessment tools

Training Type

a	content that focuses on assessing children, working with individuals or families
b	content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c	other (specify)

Training Hours

a	8-20 hours
b	20-40 hours
c	40-80 hours
d	80+ hours

unvail = unavailable

Figure 4

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THE LAWNDALE COMMUNITY, CHICAGO, ILLINOIS

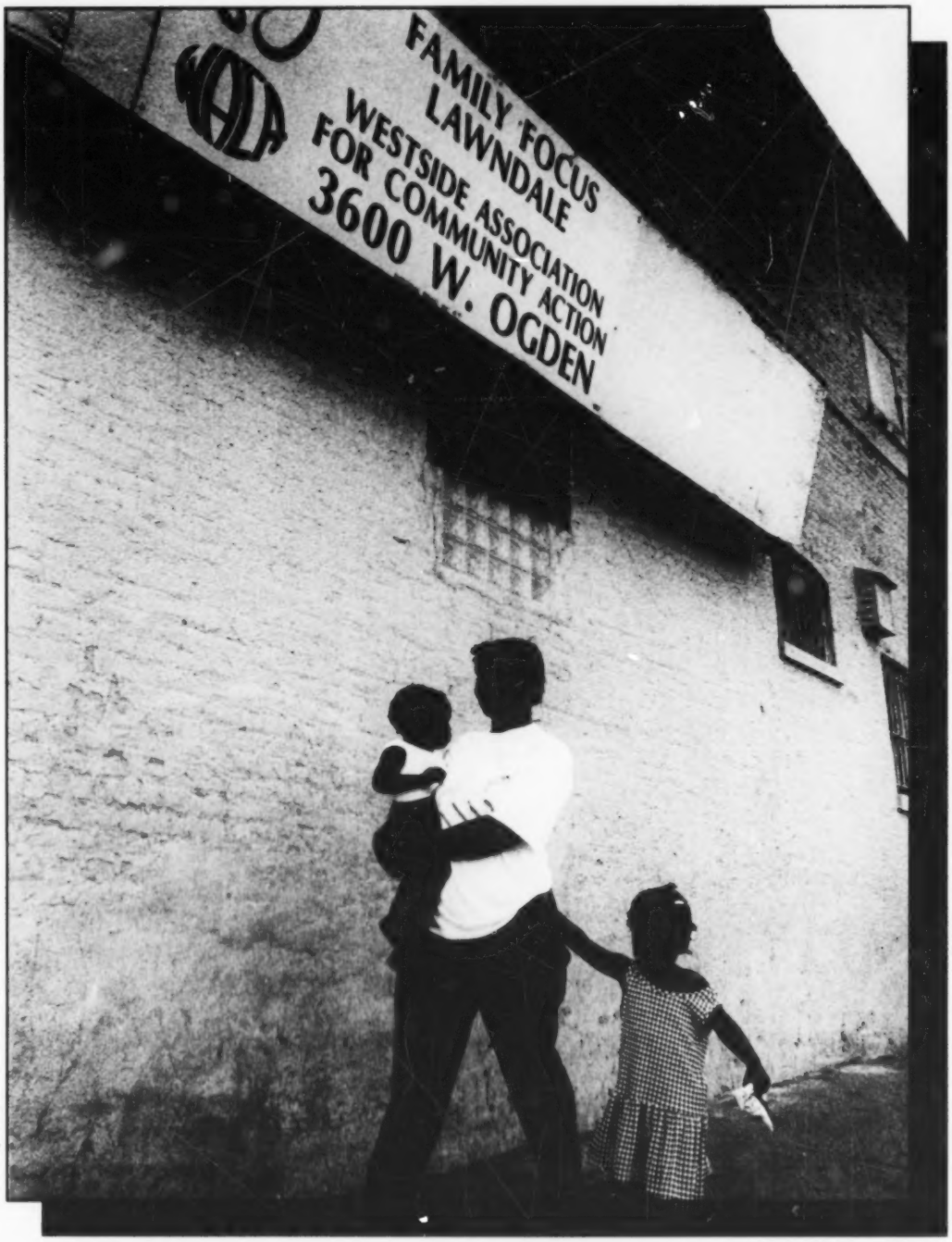

Photo by Ovie Carter - *Chicago Tribune*

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THE LAWNDALE COMMUNITY, CHICAGO, ILLINOIS

DEMOGRAPHIC PROFILE

North Lawndale is a community on the west side of Chicago. Within its 3 - mile radius lie two census tracts, which together contain more than 45,000 residents. The ethnic make-up of the community is approximately 96 percent African-American, three percent Latino, and less than one percent Asian, American Indian, Caucasian, and others combined. The community is served by 13 elementary schools, three junior and senior high schools, and seven hospitals. At least four religious centers are involved in the planning and delivery of services to the community. Also within the boundaries of North Lawndale, our respondents report, are 48 lottery agents, 50 currency exchanges, and 99 liquor stores.

Most housing in this community consists of privately-owned single-family and multi-unit residences. Although some brick row houses are quite large and architecturally impressive, many, if not most of these are in need of repair. Many community residents are homeless or at risk of becoming so. Most community interviewees ranked affordable and adequate housing as a community need second only to employment in urgency.

North Lawndale is the ninth poorest of Chicago's 77 communities. In 1980, 40 percent of its residents were living at or below the federal poverty level. In 1989, 61.7 percent of Lawndale children ages three to five lived in poverty. Former major employers such as Sears Roebuck and Co., and Western Electric have left the area, and North Lawndale's major thoroughfares are lined with boarded-up stores and shops. The Center for Urban Studies at Northwestern University estimates in a recent report that while over 67 percent of the community's residents are "employable," only 27 percent of this group are actually engaged in some type of work. Many others are underemployed in low-wage jobs. However, some North Lawndale residents do hold professional, managerial, and technical positions with public agencies (schools, social service agencies, hospitals and private health care facilities), as well as with private employers (from fast food operations to major corporations) throughout the metropolitan area.

Twenty-five percent of the community's residents age 16-19 are neither in high school nor have graduated from high school. In 1990, it was estimated that only 36 percent of students entering high school in Lawndale would graduate. The rate of violent crime is more than double that of Chicago as a whole, and while the community houses only two percent of the city's population, 10 percent of calls to the city's fire department and ambulance services originate from this community.

Lawndale's average infant mortality rate from 1984-1988 was 22.04 per thousand, compared to Chicago's overall rate of 16.23. Between 1990-92, the rate decreased to 17.4 percent. In 1989, 29.9 percent of all births in this community were to teen mothers.

HISTORICAL OVERVIEW OF THE SERVICE SYSTEM

Services for infants/toddlers and their families in the Lawndale community are coordinated primarily by Family Focus Lawndale (FFL) and (starting in 1994) a Healthy Moms/Healthy Kids Partnership funded by the Illinois Department of Public Health. Family Focus Lawndale is one of five community-based family resource centers operated by Family Focus, Inc. in Chicago, Evanston, and Aurora, Illinois. Founded in 1976, Family Focus, Inc. is recognized for its leadership in the creation of community-based family resource programs, the operation of model drop-in centers, the provision of training and internship programs, and advocacy for government and private sector policies offering support for children and families.

In 1982, a neighborhood high school principal invited Family Focus, Inc. to establish a program in the community and in the high school for pregnant and parenting teens. Initially, the proposed project drew a mixed response from the community. While residents were concerned about the incidence of teenage pregnancy, they also resisted "outsiders coming into their community" to identify needs and to attempt to address those needs. (During the Promoting Success case study team's initial site visit, all interviewees were asked for examples of something in which the community takes pride. A common response to this question was that citizens take pride in their own political activism, their politicians, and the political process that affects what happens in their communities. Clearly, sensitivity to political nuances was critical to the design, development, and success of any new community program.)

In order to obtain support and assistance in implementing the proposed project, Family Focus Inc. turned to the Westside Association for Community Action (WACA), which has been a major player in community initiatives in North Lawndale since 1971. WACA was established to promote communication and coordination of services among agencies, community organizations and local government. The organization provides informational and referral services, and operates a food and clothing bank. Its history of investment in the community endows the organization with considerable clout. Many of WACA's founding members continue to play leadership roles in the community. One such leader, when interviewed, described North Lawndale as "rich in the sense of community spirit ...people look out for each other ...it exemplifies the southern African-American value system of sharing and helping each other...residents here tend to be their own advocates rather than depending on outsiders to identify needs." She indicated that the initial resistance to the presence of the Family Focus project was based on what the residents saw as the fallout or consequences of the child-oriented social services programs of the 1960s and 1970s. She said, "About 20 years ago this was a stable and prestigious community. It changed when the government came in with the War on Poverty and stripped it of its leadership and broke up the family unit. We ended up with more problems than before they came...none of the programs said, 'Send me your families.' Instead they said, 'Send me your children.' "

Family Focus and WACA's first task was to convince the larger community of the potential benefits of a family-oriented teen parenting program and to ensure community control over the design and operation of the program. The planning and

development group coordinated by WACA included representatives from the Family Focus program, the local religious community, parents, and the Chicago Board of Education. For political and practical reasons, it was agreed that the family resource center would ultimately be housed in the building owned by WACA. This location demonstrated to the community that the Family Focus program had the support of this powerful organization. The original funders were The Ounce of Prevention Fund, MacArthur Foundation, and Continental Bank. Subcontractors included the Children's Home & Aid Society, which provided a social worker; Mt. Sinai Hospital, which provided a registered nurse and free prenatal and delivery services for FFL participants without health insurance; and Chicago Youth Centers, which provided staff support for a GED program.

When, during the second year of the teen parenting program, the community saw a decrease in the number of subsequent pregnancies to teen mothers enrolled in the FFL program, support grew for developing a more comprehensive system of services. Expectations for outcomes for the community were: a decrease in the overall number of teen pregnancies, but especially subsequent pregnancies to teen mothers; improvement in parenting skills; reduction in infant mortality; increase in high school graduation rates; and increased involvement of teen parents with their extended family.

CURRENT SERVICE SYSTEM

Figures 1 through 4 at the end of this section portray the system of family support and health services for families with young children that existed in Lawndale at the time of the case study team's site visit in the Fall of 1993. As discussed in Part I of this report, the "changing map" of services is a challenge to services integration faced by all communities in the study. Among the six communities studied, services available to families with young children have varied the most from year to year in the North Lawndale Community. While specific services or programs have come and gone, Family Focus (FFL) has remained as a central provider or organizer of family support and other services. Interestingly, during the period of the study, the Lawndale Christian Health Center (LCHC) has also developed into a multiservice agency. Both are described below. In the high-risk community of Lawndale, the public Department of Children and Family Services (DCFS) is a major presence and is, therefore, also described.

Family Focus Lawndale

Services for families with young children that are located at or coordinated by Family Focus Lawndale, include a wide range of center-, school-, home- and community-based prevention and intervention services and programs. Because FFL's philosophy is community-oriented and more "family-centered" than "child-centered," non-parenting teens are included in the service population and in FFL's census count. Many of the services to non-parenting teens are designed to support FFL's goal of reducing teen pregnancies.

- **Parents-Too-Soon**, targeting pre-teens and teens, is funded by The Ounce of Prevention Fund, a public/private partnership between the Illinois Department of Children and Family Services and the Pittway Corporation Charitable Fund. The

project offers teen parents and parents-to-be special support services that will help participants to continue their education and careers, find adequate child care, delay subsequent pregnancies, and become competent parents. It consists of center-based activities and discussion groups, counseling, school outreach, field trips, special events, advocacy, and home visits to each participant. The approach is to address the needs of the whole family; referrals and linkages are made for all family needs. Parents-Too-Soon also works with the non-parenting peers and siblings of teen parents around issues of self development and planning and preparation for parenthood.

• **Project STEP** is a pilot program aimed at reducing the medical, nutritional and social risks of the children born to teen parents. The program helps teens make the transition into adulthood by developing skills in communication, coping, decision making, and managing time and money. The program uses home visits to each participant to address the needs of the entire family. It also includes center-based parent support groups, a prenatal group, referrals and advocacy and special activities. This project is earmarked for 40 teen parents.

• **The Prevention Initiative Project** is specifically targeted to at-risk infants and toddlers and their families (serving 410 children in 1990). It is funded through the Illinois State Board of Education (originally in collaboration with six other state agencies - the Department of Children & Family Services; Department of Public Aid; Department of Rehabilitation Services; Department of Alcoholism & Substance Abuse; Department of Mental Health & Developmental Disabilities; and Department of Public Health). A comprehensive, community-based infant/toddler development program, the Prevention Initiative includes screening and assessment; development of an Individualized Family Service Plan (IFSP); bi-weekly home visits for parent-child interaction activities; use of the HOME Inventory for the assessment of the home environment; and parent education activities using the Family Focus curriculum. A strong component of this program is the intensive case management required for advocacy and support in accessing and maintaining other support services such as housing, health care, and financial assistance. Services may take place in the home, at the Family Focus Center, in schools, or at other neighborhood locations.

• **The Family Literacy Program (Together We Grow)** serves parents in the Prevention Initiative. This is a joint program between FFL and the Chicago Board of Education, which provides adult basic education, GED, computer literacy, job training, nutrition, home economics and parenting skills. The classes are offered at the FFL facility, and at two elementary schools. Through this program, FFL has a formal agreement for referral, training and job placement with a local Jobs Training Partnership Act contractor.

• **Healthy Moms/Healthy Kids (HMHK)** is funded through the Illinois Department of Public Aid and the Illinois Department of Public Health. There are twelve agencies (public and private) under the HMHK program. HMHK also has joint partnerships with two area hospitals, Mt. Sinai and Bethany. Clients may register for the program at any local Public Aid office. HMHK serves all infants and toddlers ages birth to 6. Family Focus Lawndale, as a participant in HMHK, provides many of the same services as it did under the Families with a Future/Infant Mortality Initiative,

the predecessor to HMHK. Outreach workers go door-to-door, make follow-up home visits, and are stationed at the Pediatric and OB-GYN clinics of both Mt. Sinai and Bethany hospitals.

• **Parent groups** at Family Focus Lawndale include: 1) parent support groups that meet weekly to share information about child rearing and parent support strategies; 2) two "Caring Connection" parent-child interaction groups with pre-planned activities designed to strengthen the parent-child bond (there are separate weekly classes for parents of infants and parents of toddlers); and 3) Effective Black Parenting, a 15-week, intensive parenting education class that is culturally specific to African-Americans. It was developed by the Center for Improvement in Child Caring with special funding from the Illinois Department of Alcohol & Substance Abuse. Participants include fathers who are pursuing custody of their children or those mandated to attend by Protective Services. The group is open to the community at large, although most of the referrals come from the Department of Children & Family Services.

• **Project Success**, funded and administered by the Governor's Office, supports a Family Focus Lawndale staff person in two local schools to facilitate community resources for families and bring needed programs into the school. Lawndale is one of six pilot communities for this program, the goal of which is to use schools as the focal points for coordination of community and state services, in order to help children deal with family and health problems that could interfere with their education.

• **The Transition Program** involves FFL staff teams in assisting parents with identifying resources and linkages to preschool programs and obtaining immunizations and physical examinations for children. Through an informal arrangement with the state Pre-Kindergarten At-Risk Program, FFL three- and four-year-olds are guaranteed slots in prekindergarten programs reserved for children "at medical, developmental, or environmental risk of academic failure" even though the children who have participated in FFL programs may score too high on developmental tests to qualify as "at risk."

As noted above, the service system map changes frequently in Lawndale. Sometimes programs are consolidated or subsumed into a new initiative. For example, Families with a Future was replaced by Healthy Moms/Healthy Kids. Sometimes, however, a project is short-lived. For example, the Better Homes Foundation provided one year of funding to support a previously informal agreement between FFL and local shelters for the homeless, through which FFL provided child assessment, family support groups and advocacy services. With foundation support, an FFL-based Housing Services Coordinator negotiated placement at the shelters for FFL families as needed and developed other more permanent housing resources in the Lawndale community. The project ended in 1993.

Lawndale Christian Health Center

Lawndale Christian Health Center (LCHC), a church-operated health program, is one of two community-based health centers in Lawndale (the other is the Westside Family Health Center, a Health Maintenance Organization that accepts Medicaid).

Both its history and the range of family support services that it provides give this center unusually strong connections with the community.

The Center was established by The Rev. Wayne Gordon, a public high school teacher and coach, who moved into the Lawndale community in the mid-1970s and started a Bible study group with high school students. This led to the establishment of the non-denominational Lawndale Community Church. The church conducted a needs assessment of the community and identified housing, education, and health as priorities. In the mid-1980s, Dr. Arthur Jones, a cardiologist and member of the Lawndale Community Church, and Dr. Pam Smith, an obstetrician/gynecologist who had grown up in North Lawndale, used a Robert Wood Johnson Foundation grant to start a clinic in the neighborhood.

Lawndale Christian Health Center is now part of the Christian Community Development Association (CCDA), a national organization, founded by The Rev. Gordon and other ministers, that develops and supports community-based health and social service programs. Within CCDA is a national network, the Christian Community Health Fellowship, which is the source of the health care professionals who work as staff and volunteers at the Center.

LCHC now has 14 physicians on staff, including specialists in pediatrics, internal medicine, family practice, OB-GYN, cardiology, and infectious diseases. It also has a dentist who grew up in the community and a full-time X-ray technician. The clinic is also served by volunteer specialists in orthopedics, dermatology, ophthalmology, radiology, and optometry. The clinic pharmacy provides medicines at cost. LCHC records 800 to 1,000 patient visits each week.

The Center no longer receives Robert Wood Johnson funds. It is currently supported by a mix of foundation and Federal grants for pediatric primary health care services for children who qualify for public aid; United Way funds that support two staff located in the Public Aid Office to do outreach and a physician in the Public Aid Office who provides initial prenatal examinations; and Department of Public Health funds supporting a nurse who comes to the Public Aid office to provide immunizations. The largest single funder for the Center at this time is the Federal government.

LCHC was recently designated a Federally Qualified Health Center (FQHC). According to the Medical Director, the Center had been reluctant to apply for FQHC funding because staff see themselves "as part of a Christian Ministry and were concerned that federal regulations and requirements would affect the way they practice medicine." However, FQHC funds allow the Center to operate as a Healthy Moms/Healthy Kids program (described above) and support the My Baby and Me prenatal classes in infant care and development and family planning. A nurse from LCHC conducts weekly pre-natal classes at FFL under a formal agreement through the HMHK program.

In addition to health care services, LCHC offers many programs similar to those offered by Family Focus Lawndale: an after-school tutoring and recreational program targeting first- through eighth-graders; a job readiness program for adults; and

a college mentoring and scholarship program that starts with eighth-graders. The Center has a variety of outreach materials, published in English and Spanish.

The Department of Children and Family Services (DCFS)

In North Lawndale, the Department of Children and Family Services either provides directly or contracts for and monitors many, if not most, of the services available to families with young children. Both the way the services are organized and the context in which they are provided illustrate the challenge of serving families in inner city communities.

The DCFS facility that serves families in North Lawndale is a former supermarket with a large parking lot. It has been renovated into a spacious and attractive building. However, a sign prominently displayed on the front of the building pictures a snarling dog and states that the building has a 24-hour security patrol. When the case study team interviewed the Director of the facility during two hours on a weekday morning, there were no signs of parents or children anywhere in the building.

During our interview, the Director described herself as "pretty removed from the system" of community-based health and family support services in Lawndale. She said her workers were the ones with the contacts, which were on a case-by-case basis and tied to "well-established relationships" with community service providers. At the time of our interview with the Director, the Department was receiving a great deal of attention in the media regarding the case of a toddler who had been removed from foster care and reunited with his mentally ill mother, who then hanged the child. The day before our interview, an Inspector General had been appointed by the courts to oversee Department operations. While the interview was being conducted, there was a great deal of activity around the office in response to telephone calls regarding the incident and the subsequent developments, and at one point a worker walked into the office and handed her resignation to the Director. The Director said this was another of several resignations that were tied to the negative publicity associated with the death of the child. The publicity was intensified after a reporter exposed the identity of the worker who was assigned to the case and television crews began to follow the worker.

For the past two years, the Department had been under a court order to reduce caseloads to 25 per worker and had received substantial funding to implement a massive hiring program. However, at the time of our interview workers had caseloads averaging more than 100 families. The Director acknowledged the challenge of trying to come into compliance with the court order in the face of negative publicity and a "wave of resignations."

In spite of the volume of work and the circumstances of our interview, the Director demonstrated an in-depth knowledge of the range of community services that her department funds, of the quality of the services provided and of the relationships between programs. Examples of services funded by DCFS in the Lawndale community include:

Health-related services: All children under DCFS supervision have a Department of Public Aid card that purchases health care services and a Medical Book. The Medical Book is a parent-held medical record for the child that is used to record each health services contact. Records are reviewed by DCFS workers when they visit families. DCFS also co-sponsors a project that tracks children diagnosed with HIV or AIDS.

Family Support Services: An informal agreement between the regional administrator for Protective Services and Family Focus Lawndale addresses funding, collaboration and referrals for many of the programs mentioned earlier, such as the Effective Black Parenting Group.

COMMUNITY SELECTION CRITERIA AS REFLECTED IN LAWNDALE

Universal access to services

The issue of universal access to services in North Lawndale must be understood in the context of the community's demographic profile, which has earned the designation of an area of "environmental risk." Consequently, all children and families in the community are eligible for prevention services funded by the Board of Education. In practice, resources are not sufficient to accommodate the needs of all families, but Family Focus makes an effort to involve families in some appropriate activities as a way of maintaining contact until openings occur in programs that may match a family's needs most closely.

Although the Lawndale community is a single neighborhood, tiny in size compared to other study communities (Lawndale covers 3.5 square miles, Snohomish County more than 2,000) and most families who use Family Focus live within walking distance of the center, the issue of "psychological accessibility" of services is a real one in Lawndale. As described above, Family Focus and the Lawndale Christian Health Center not only try to offer multiple services at their own sites but also place staff in the Public Aid office and in schools to enhance accessibility. FFL provides center-based services Monday through Friday, from 8:30 a.m. to 7:00 p.m. Since so many of the community's parents are unemployed, these hours have not been seen as a barrier. Some neighborhood health clinics, including LCHC, are open evenings and Saturdays.

Inclusive, non-categorical settings for services

The services provided and coordinated by Family Focus Lawndale may be described as non-categorical in that most of the children served are not "disabled or delayed," but rather, come under the program's rather flexible definition of at-risk. Drop-in child care services are provided to parents coming into the center for other purposes. All center-based early intervention activities are provided in an integrated setting. The Fletcher Head Start/PCC serves children in an integrated setting and provides diagnostic evaluations, consultation, and limited treatment for children with disabilities, as well as assistance in obtaining adaptive materials.

Professional development opportunities

Training for Family Focus Lawndale staff is provided through Family Focus, Inc.'s own training department and contracts with private providers. Staff occasionally attend seminars and workshops at local colleges and universities. In the past, Family Focus Lawndale has had a contract with two psychologists for on-site staff development through case staffings, workshops, and consultation. Interviews with the case management staff reflect that most of the training has been in infant/child development and family systems. However, staff observed that trainers from outside the community tend not to understand the population served by FFL, so that training (for example, a year-long course in teaching parenting skills) is inappropriate or of limited value. FFL staff reported a need for training in culturally competent assessment and intervention techniques, and techniques for teaching parenting skills. They also expressed a need for stress management and supervision and management skills.

Notwithstanding FFL staff's expressed need for additional training themselves, their success in providing comprehensive services has led to requests by other programs for technical assistance in how to provide family-oriented services. Family Focus' consultation and training program with the Salvation Army illustrates this sharing of expertise. In this effort, the FFL Center Director provides consultation to Salvation Army staff on strategies for family oriented comprehensive services during regularly-scheduled meetings and through telephone consultation. Family Focus' home education staff trained their Salvation Army counterparts using the *Home Educator Guide* (developed by Family Focus and The Ounce of Prevention Fund), which teaches principles and techniques for working successfully with families in their homes. These home educators joined FFL staff on visits to participants to learn first-hand how to put these principles and techniques into action. FFL has begun charging other programs for the training and technical assistance they provide for them.

Commitment to family support and leadership

Lawndale parents interviewed by the case study team described several types of opportunities and support for parent leadership. They had high praise for the Fletcher Head Start Parent-Child Center, which pays parent representatives to attend workshops and advisory committee meetings and pays for transportation and child care for parents to attend meetings. Fletcher PCC also recruits parent volunteers for classroom assistance, providing transportation for these volunteers. Parents also recognized the ABC Child Development Center as a program that actively seeks parent participation on committees.

Family Focus Lawndale reflects a strong family orientation in its organization and services. Family involvement in FFL spans the continuum from participation in support groups to career ladder opportunities for staff positions. The majority of FFL staff members live in the community. Most FFL parent involvement is in direct services contact with other parents. However, a few parents have moved into the role

of spokespersons for FFL and the community at state and national meetings. At the time of the 1993 site visit, parents did not seem to be playing a formal role as planners, trainers, or program evaluators.

CRITICAL ISSUES REFLECTED IN THE LAWNDALE COMMUNITY

Linkages across a range of levels of care and service system needs

All of the Lawndale interviewees describe Family Focus Lawndale as the primary organization for providing leadership on addressing system-wide issues for families with young children. Thus Family Focus is the fiscal agent for a planning grant given by the Chicago Community Trust to the North Lawndale Family Network to develop a comprehensive plan for a "Children, Youth and Families Initiative" for North Lawndale. Family Focus also works closely with The Problems Resolution Office (PRO), a partnership between the Governor's Office and Kids PEPP (Public Education and Policy Project). PRO serves as a liaison between community-based programs and the Governor's office; its specific mission is to encourage service agencies to identify policies and procedures that are barriers to direct access to services or to collaborative efforts at the community level. Using this resource, Family Focus Lawndale has submitted requests to the Governor's Office for specific waivers to existing policies, changes in system procedures, and the assignment of state agency liaisons to Family Focus Lawndale to enroll participants in state programs. Some of the waivers were granted; others were not. However, the consensus among interviewees was that the process of submitting the requests and identifying the procedural issues will have a positive impact on state systems by focusing attention on barriers to full services for families.

FFL has become the central coordinator for families' access to pre-natal care, immunizations, Medicaid, WIC, day care centers and licensed day care homes, Head Start, and diagnostic services. In addition, staff devote considerable time to making referrals to job training programs, adult education programs, and housing services that run the gamut from emergency shelters, and energy assistance to fair housing complaints and inspection services. FFL case management staff interviewed by the case study team said that a "disproportionate" amount of their time and energy is spent advocating for services for families when access is denied or in supporting and educating parents on how to utilize the services, rather than in providing counseling or other direct services related to families' own functioning. This observation raises the issue of how a community-based program allocates staff resources among direct service, case-oriented service coordination, and administrative coordination, or system-change efforts.

In contrast (or perhaps as a consequence of ceding this role to FFL?), other family support programs in the community describe limited experience with linkage and/or collaboration for planning or systems development purposes. The Head Start/PCC staff share referrals with DCFS staff (especially Child Protective Services), but collaboration is limited to case management issues. The PCC has a contract with Lawndale Christian Health for health screenings, but there are no meetings or contacts other than for referrals. The DCFS administrator described limited communication with community programs and providers as a result of her staff's lack of time to attend

community meetings. She describes good relations among her staff, Department of Public Aid staff, and the child care providers who serve children under DCFS supervision, but "there is never time to meet to discuss system-wide issues." Although DCFS contracts for health services with community-based HMOs, contracts are described as "on a case-by-case basis" and mainly in regard to crises.

Although, as described above, Lawndale Christian Health Center offers an impressive array of family-centered services and assigns a nurse to give prenatal classes at FFL, the Medical Director and Health Educator/Case Manager described little or no contact with other community providers except around issues concerning specific families. The administrator identified as LCHC's contact with community planning groups demonstrated limited recognition of key players in the community or knowledge of initiatives being proposed by other agencies.

State support and encouragement

Interviewees focused on two factors that affect the quality of state support for family-oriented services in the city of Chicago, and consequently in Lawndale:

- Chicago, because of its size and demographics, receives more funding for schools and health programs through different mechanisms than do other cities/counties in the state; and

- state agencies are organized and administered in a manner that, according to interviewees, discourages collaboration around early childhood issues.

According to one state official, "Chicago gets a whole chunk of money for certain programs from the Federal and state governments that comes as separate funding directly to the city; there are no state requirements and no state administration by the state for these programs...therefore, a lot of the bureaucracy in the communities is established at the community level." She gave as an example the city's immunization program. Chicago, which has an immunization rate of 29% for children under five compared to the state rate of 79%, gets funds for immunization efforts directly from the state.

At the state agency level, one respondent described "structural and operational separation of early childhood services and early childhood special education services within the State Board of Education." The Part H program is in the Division of Special Education, and the Prevention Initiative is in the Division of Student Development and Early Childhood. Although the Program Directors meet, share information and review RFP's together, because the two programs are in different divisions they have separate relationships with all other agencies with whom they share the same constituency. This costly arrangement results in a redundancy of effort on the part of the agencies to whom they relate and slows down service delivery at the community level.

While State Board of Education representatives interviewed by the case study team were able to cite councils and committees whose purpose is to support collaboration (state and local interagency councils under Part H; Project Success Steering Committee -- which has state Board of Education representation), contact between the administrators of these early childhood programs appears to be limited. In fact, neither of the state coordinators of the Part H program (a key player in early childhood in the state for many years) or the Governor's Special Assistant for Project Success recognized the other's name, even after some prompting by the interviewer.

State support of professional development is sometimes a case of mixed signals. The Coordinator of the State Part H program expressed concern that "there are still separate training programs within our agency being funded through the 'at-risk' program areas and the special education areas. The training overlaps regarding their early childhood attendees, but we have not been able to successfully merge them." On the other hand, our liaison at FFL states that "more recently the Illinois State Board of Education has instituted a comprehensive staff development program which serves all of its early childhood education initiatives, the state pre-school programs, and Parents as Teachers programs." This would appear to be a move in the direction of addressing the collaboration barriers cited above.

Family Focus, Inc. has a history of working with state agencies to serve families and has received considerable public recognition for its efforts. The Executive Director of Family Focus, Inc. noted, however, that state agency representatives "tell us that our program is doing exactly what we are supported to do" but nevertheless cut Family Focus' budget from $405,000 in FY 1991 to $328,000 in FY 1992 and $296,000 for FY 1993." In spite of her frustrations, the Director was able to describe "effective linkages and collaborations at the state-level emanating from the Governor's office" through Project Success, a program that emphasizes "one-stop shopping" as a way of developing "a system of comprehensive coordination of health and social services for the child and family." Project Success is being tested in six sites around the state, each with its local steering committee. Family Focus Lawndale is one of the sites. The FFL Director observed that "the funding (for Project Success) is inadequate, but the level of in-kind interest and support from state agencies is indicative of the value of the Governor's leadership in setting state agency priorities." Another example of a state-level response established to address the operational challenges typical of bureaucracies is the Governor's Problem Resolution Office, discussed above. While not a panacea, it is praised by those who use it as a step in the right direction.

COMMUNITY SYSTEM FOR FAMILIES WITH YOUNG CHILDREN
NORTH LAWNDALE, CHICAGO, ILLINOIS

RELIGIOUS COMMUNITY

Westside Center for Truth for Better Living
Faith Deliverance Baptist Church
Christian Community Development Assoc
- Christian Community Health Fellowship
- Lawndale Christian Health Center

COMPREHENSIVE POLICY AND PLANNING BODIES

FAMILY FOCUS, INC

Westside Association for Community Action (WACA)

STATE AGENCIES

Dept of Children & Family Services
Dept of Public Health
Illinois Dept of Public AID
Dept of Rehabilitation Services
Alcohol and Substance Abuse Programs
Mental Health & Mental Retardation/ Developmental Disabilities
Governor's Problems Resolution Office/ KIDS PEPP

EARLY CHILDHOOD SERVICES SYSTEM

FAMILY SUPPORT

- Family Focus Lawndale
  - Parents Too Soon
  - Prevention Initiative Project
  - Parent Groups
  - Family Literacy Program
  - Project STEP
  - Better Homes & Gardens Proj
  - Families with A Future
- Head Start/PCC
- Dept of Children & Family Services
  - Child Welfare
  - Child Protective Services
- Lawndale Christian Health Center

HEALTH SERVICES

- Lawndale Christian Health Ctr
  - Healthy Moms/Healthy Kids
  - My Baby and Me
- Westside Family Health Center
- LaRabida Children's Hospital
- City Health Department
- WIC
- Women's Treatment Center for Pregnant and Parenting Women
- Dept of Public Aid
  - The Medical Book
  - Healthy Start
- Perinatal Program (State Dept of Health)
- AIDS Project
- Drug Free Families with A Future
- Lawndale Mental Health
- Bobby Wright Mental Hlth

EARLY CHILDHOOD EDUCATION

- Chicago Board of Education
  - Transition Program (State Pre-K)
  - Head Start
- Title XX Day Care Program

EARLY CHILDHOOD PLANNING BODIES

Lawndale Family Network
Project Success Steering Committee
Local Community Council
Prevention Initiative
Local Interagency Council (LIC)

Local Shelters

Child Care
Local Child Care Providers

NORTH LAWNDALE, CHICAGO DEMOGRAPHIC PROFILE

TOTAL POPULATION	STATE	COMMUNITY
• total population	11,430,602	47,296
• African-American	13 %	95 %
• American Indian	< 1 %	< 1 %
• Asian	1.5 %	< 1 %
• Caucasian	77 %	1 %
• Latino	6 %	3 %
• Other	2 %	< 1 %
• below poverty level	11.9 %	unavailable
• unemployed	6.2 %	22.6 %
• Medicaid recipients	10.1 %	32.1 %
• WIC recipients	34.1 %	unavailable
• high school grads	78.4 %	36 %
• Live births - all ages	58.5 %	25.5 %
• Live births maternal age <18 years	13.1 %	29.1 %
• Low birth weight	7.6 %	13.7 %
• Infant mortality	10.7/1000	21.6/1000

LOCAL SERVICE SYSTEM PROFILE	LIAISON PROGRAM	COMMUNITY SERVICE SYSTEM
• total 0-3 served	410	not available
• of 0-3 served, % poverty level	100 %	not available
• total direct service staff	36	not available
• bilingual staff & sign language	0	not available
• total ethnic minority staff	34	not available
• total staff live in community	19	not available

The information presented here represents data from 1990. See Appendix B: Community Case Study Issues for discussion of accessibility of statistical data and its implications for service planning and delivery.

Figure 2

Chart I	Major Funding Source	Universal Access 0-3	Ease of Access	Cultural Inclusve	Center or Home Base	# Indiv Served 1990	Referal Follow up	Training Type	Training Hours	Staff Turnover	Parent Involvmnt	Eval.
Prenatal Hlth Svcs.	d	yes	b	a,b	center	n/a	yes	unavail	unavail	unavail	unavail	unavail
Perinatal Svcs.	d	yes	b	a,b	center	n/a	yes	unavail	unavail	unavail	unavail	unavail
Teen Preg. Prog.	d	yes	b	a,b,d	both	130	no	b,c	a,c	unavail	b,c,d,e	a,b
Childbirth Educ.	d	yes	b	a,b	both	130	yes	a,c	a	0%	b,c,d,e	unavail
WIC Program	d	yes	b	a,b	center	n/a	yes	unavail	unavail	unavail	unavail	unavail
Head Start	e,fed	yes	d,e,f,g,h	a,c	center	168	yes	a,b	a	10%	a,b,c,d	a,b,d,e
Primary Hlth. Care	d	yes	b,c	a,b	center	n/a	yes	unavail	unavail	unavail	unavail	unavail
Immunization	d	yes	b	a,b	center	n/a	yes	unavail	unavail	0%	unavail	unavail
Parenting Instruction	d	yes	a,b	a,b,d	both	270	yes	unavail	unavail	0%	a,b,c,f	a,d
High Risk Registry	d	no	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
Inf/Tod.Dev. Screening	d	yes	a,b,f,g	a	both	151	yes	unavail	b	0%	b,c,d,e	a,d
Tracking System	d	no	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
Child Care	b,d	yes	a,b,c,g	unavail	center	75	yes	unavail	unavail	unavail	unavail	a,d
Early Intervention Infants	d	yes	d	unavail	both	n/a	yes	unavail	c	0%	unavail	unavail
Toddlers	d	no	d	unavail	both	n/a	yes	unavail	c	unavail	unavail	unavail

KEY

Major Funding Source

- a private
- b public: local
- c public: county
- d public: state
- e federal
- f client fees
- g 3rd party
- h other

Ease of Access

- a central geographical location
- b flexible hours of service
- c accessible to public transportation
- d transportation provided for the disabled
- e transportation universally provided
- f bilingual staff (including for hearing impaired)
- g wheelchair accessible
- h waiting lists monitored and updated
- j other

Cultural Inclusiveness

- a population served is culturally and/or economically reflective of the population in need of services
- b public awareness campaigns target diverse groups
- c staff reflect the diversity of the population serviced
- d use culturally appropriate/sensitive assessment tools

Training Type

- a content that focuses on assessing children, working with individuals or families
- b content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
- c other (specify)

Training Hours

- a 8-20 hours
- b 20-40 hours
- c 40-80 hours
- d 80 + hours

Parent Involvement

- a as member of child's staffing team
- b in support groups
- c in parenting classes
- d on advisory committees
- e as board member
- f as staff
- g other

Evaluation

- a self administered
- b parent agency administered
- c county administered
- d state administered
- e federal
- f all of the above
- g other_____specify
- h parents are a part of the evaluation team

unavail = unavailable n/a = not applicable

Figure 3

BEST COPY AVAILABLE

Chart II	Major Funding Source	Universal Access	Recruitmt Enrollmt Type	Services Offerred	Ease of Access	# Indiv. Served 1990	Referral w/ Followup	Family Needs Assessmt	Indiv. Svcs.	Group Svcs.	Support Groups	Cultural Inclusive	Training Type	Training Hours
GED Classes	b	no	a,b,c,d	a,b,c,d	a,c,g,h	19	a,b	yes	no	yes	n/a	a,b,c	c	a
Employment Counseling & Placement	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Housing Assistance	n/a	no	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Financial Assistance (Medicaid; AFDC; SSI)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mental Health Evaluation & Referral	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Substance Abuse Treatment	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Child Abuse Prevention & Detection Program	d	yes	a,b,c,d	a,b,c	a,c,g,h	275	a,b	yes	yes	yes	yes	n/a	a,b,c	c

KEY

Major Funding Source

a	private	e	federal		
b	public:local	f	client participant fees		
c	public county	g	3rd party payment		
d	public state	h	other		

Recruitment/Enrollment Type

a	self referral
b	referrals from other programs
c	outreach from this program
d	other

Services Offered

a	Direct services
b	Screening/assessment
c	Referal for other services
d	Other

Ease of Access

a	Central geographical location	f	Bilingual staff (including for hearing impaired)
b	Flexible hours of service	g	Wheelchair accessible
c	Accessible to public transportation	h	Waiting lists monitored and updated
d	Transportation provided for the disabled	i	Other
e	Transportation universally provided		

Cultural Inclusiveness

a	population served in culturally and or economically reflective of the population in need of services
b	public awareness campaigns target diverse groups
c	staff reflect the diversity of the population serviced
d	use culturally appropriate/sensitive assessment tools

Training Type

a	content that focuses on assessing children, working with individuals or families
b	content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c	other (specify)

Training Hours

a	8-20 hours
b	20-40 hours
c	40-80 hours
d	80+ hours

n/a = not applicable

Figure 4

BEST COPY AVAILABLE

SCOTT COUNTY, INDIANA

BEST COPY AVAILABLE

SCOTT COUNTY, INDIANA

DEMOGRAPHIC PROFILE

Scott County is located in the southeast quadrant of Indiana in a rural, traditionally agricultural area. Approximately 20,000 people live in Scott County; the two largest communities, Scottsburg (the county seat) and Austin, each has about 6,000 residents. The county has seven elementary schools, two junior high schools, and two high schools; one 107-bed hospital; and more than 80 churches.

During 1985-89, Scott county had one of the highest rates of births to teens in the state (20.7 percent of teens between the ages of 15-18 had babies) and the lowest percentage of adult residents with high school diplomas (38.6 percent). However, the county infant mortality rate was 6.1 per one thousand in 1990, as compared to the state's rate of 9.6 and the county's low birth weight rate was 6.4 per one thousand, as compared to the state rate of 6.6. In 1990, 19 percent of county residents had incomes below the poverty level (the highest rate in the state). The county's rate of food stamp utilization is also the highest in the state, 12 percent. The ethnic makeup of the county in 1990 was 99 percent Caucasian and 1 percent combined American Indian, African American, Hispanic/Latino and Asian.

Until the 1980's, food processing companies and manufacturers had been major employers, but these companies eliminated jobs and eventually closed down. In 1989, when this study began, the county had been dealing with the results of an economic decline. However, since 1990, its economic status has stabilized and is giving evidence of growth. The county's rate of unemployment fluctuated between 7 and 13 percent for a decade but has recently decreased to less than 5 percent.

The county's experience of economic decline was reflected in demographic data. For many years, most young people who graduated from high school or college left the county to seek employment. Those who remained, because of low educational achievement, had a hard time finding even entry-level jobs. Unemployed young people have become involved in alcohol and drug abuse, unwanted pregnancies, and spouse abuse.

In 1990, the largest employer in the county was Holm Industries, a plastics company. The school system provided a large number of entry-, mid-level and professional jobs to county residents. Four new industries opened for business since 1990. The Japanese-owned Kokoku Steel Cord Corporation (K-Cord) opened a 15-acre plant in 1990, currently employs more than 200 people, and is seen as a potential attraction for other economic development.

HISTORICAL OVERVIEW OF THE SERVICE SYSTEM

Scott County residents point to the Kids Place building itself as the center of the service system for infants and toddlers. The concept for this "one stop shopping" center for families grew out of concern on the part of community service providers and families that urgent needs were not being met, in part because of a tradition of pride in "taking care of one's own." (The county has been described by those interviewed as a

community whose residents admire self-sufficiency, independence, and their winning basketball teams.) Consequently, low demands on such county public services as health, education, and child welfare did not reflect actual levels of need. The county was served by New Hope Services, a private, not-for-profit agency that provides support services for high-risk and developmentally disabled children and their parents. Although New Hope was based in Clark County, their statistics revealed as many children in need of special services in Scott county as in Clark county.

In 1986, the Associate Director of New Hope Services convened a group of concerned service providers and family members who came up with the idea for a multi-service children's center. The group approached the Mayor of Scottsburg and asked him to organize a meeting of business and community leaders to solicit support for the proposal to build Kids Place. They responded with enthusiasm. Grant applications were submitted by New Hope Services to private foundations, corporations, and state funding programs to secure $650,000 dollars. A state grant from the Indiana Legislature, awarded to New Hope Services, provided the initial $375,000 dollars. The remainder of the money was raised from a local television station (WHAS) Crusade for Children; the Ronald McDonald Children's Charities; a Mary and Barry Bingham Fund Grant; and community donations and local residents' fundraising efforts, such as skating parties and bake sales, which yielded $100,000 dollars. Local residents were brought into the process at the outset through fairs, parades, and other public awareness activities. This early involvement of the community in the fund raising for the facility produced a strong sense of community identification and ownership of the service system that has been developed. The committee of service providers, community members, and family members met for two years, planning the scope of services, raising money, and building community awareness.

In 1992, the State of Indiana implemented its Step Ahead Initiative -- a state-wide comprehensive service delivery system for children birth to thirteen. This initiative established state and county level councils which are responsible for planning and coordinating services. Scott County programs and services are now connected to the Step Ahead Initiative.

CURRENT SERVICE SYSTEM

The Scott County system of services for families with young children can be described as a primary system of family-oriented services housed at the Kids Place facility associated with a secondary network of early intervention, family support, health, and child care services. The planning bodies that link and coordinate these services are also a part of this larger system. The system as a whole is portrayed in Figures 1 through 4 at the end of this section. Kids Place and the local Step Ahead council are described in some detail.

Kids Place

Opened in 1988, Kids Place looks like a stack of brightly colored children's blocks. It is centrally located on SR56, a major state road. The facility contains the core of the county's service system for infants and toddlers, housing several programs

of New Hope Services Inc., including Scott County's first state-licensed day care center; preschool programs for children ages 3-5 with developmental delays; the Scott County WIC program; the Scott County Health Department; and the Ohio Valley Opportunities Head Start Program.

• **The New Hope Services First Steps Infant-Toddler Intervention Program** is funded through the Indiana Part H program (First Steps) and provides an array of family-centered programs. Services are home-, center- and school-based. They include: child care; after school care; special education preschool; a high-risk toddler classroom; Welcome Baby Baskets; Homestart Early Intervention; Child Evaluation and Assessment with Individual Family Service Plans (IFSP); speech, occupational, and physical therapy; teen parent programs; parent/baby play groups; home-based parent education; parent support groups; resource and referral services; and transportation.

In 1990, New Hope's First Steps program served 97 families and 120 children ages 0-3. Of the infants and toddlers served, 60 percent were at the poverty level and 85 percent were covered by Medicaid. First Steps has a staff of 10 who provide direct services to infants/toddlers and their families; eight of these staff members live in the community.

• **WIC at Kids Place** is the satellite office of a three-county program, sponsored by a hospital in Dearborn County.

• **The Teen Parent Program** offers parenting workshops for parents of pre-schoolers who are receiving WIC and weekly parent education classes at the two county high-schools.

• **The County Health Department** is located at Kids Place. It is responsible for communicable disease control, Well Child Services, environmental sanitation, maintenance of vital records, public health nursing and home nursing care. The County Health Department is experiencing a revolution that has its roots in the impact of Kids Place on the community. According to the interviewee representing the Health Department, over the past few years, the Health Department "has moved up in the eyes of the community; we are now seeing an increased caseload and need more space." The Department has negotiated a lease to relocate to a building adjacent to the Scott Memorial Hospital.

A public health nurse operates the immunization clinic and is the Director of the new Well Child Clinic funded by the state Maternal and Child Health Department through the County Health Department. This clinic is the only EPSDT provider in the county. Services are provided by a nurse practitioner, an RN, a social worker, and two clerks.

• **Child Protective Services** offered at Kids Place include day care for families that are at risk of either welfare dependency or abuse and neglect, supervised visitation for children in protective services, and respite care services.

• **Ohio Valley Opportunities (OVO) Head Start** uses Kids Place staff and programs to serve 18 children. In addition, Head Start provides transportation, medical, dental, vision screenings and follow-up; speech/hearing therapy; mental health services; parent education; and social services.

The Step Ahead Council

Under the state Step Ahead Initiative, every county has a local Step Ahead Council, which develops action plans based on a needs assessment. The initiative is designed to ensure that the same kind of participation and planning will occur at both the state and local level. Local councils include county-level representatives of health, education, jobs and training, recreation, art, religious, volunteer, small business, corporate, minority, social service, special needs, housing, child care, and higher education institutions and organizations, as well as consumers. Local councils may have special interest committees, such as First Steps (Part H) and Child Abuse Prevention. The councils meet monthly and state-level consultants visit counties to provide technical assistance. Annually, the counties bring their action plans to the state's advisory "Kitchen Cabinet" on service coordination and integration to discuss concerns and identify resources. This process allows local council members to have face-to-face contact with state agency staff responsible for the particular program about which they have concerns.

COMMUNITY SELECTION CRITERIA AS REFLECTED IN SCOTT COUNTY

Universal access to services

The Kids Place system of services offers Scott County families a wide range of services that, with some exceptions, are generally accessible without regard to preliminary diagnosis or other eligibility guidelines. Where eligibility criteria do exist (e.g., the WIC program), the centralized location and the collaborative environment of Kids Place facilitates applications and referrals between WIC and other early childhood services.

The most universal of Kids Place services is the Welcome Baby Basket program, operated under First Steps. When Kids Place is notified of a new birth in the county by WIC, the Health Department, or the hospital, an outreach worker delivers a basket that contains gifts for the baby and information on resources for the family. If risk factors are noted by the outreach worker during the visit or through referral sources, the family is referred or is offered referral to the First Steps Program for a range of services beginning with a family assessment. The Indiana Part H program eligibility guidelines cover children determined to be at risk of developmental delay because of physical, biological, social or environmental factors. A family may be eligible for several other programs, including parent education through group or home-based instruction; weekly parent-infant play groups; and center-based services for the child. Referrals to community services and support networks, as well as follow-along service are included on an IFSP. The First Steps Advisory Committee conducts regular outreach activities, such as a parent fair, to increase awareness and access to services.

So far, Kids Place programs work to provide services to all families that apply. They have been able to do this by mixing and matching funds from a variety of local, state, and federal sources. The challenge that this presents, including the continuous need for finding private resources to "fill in the gaps," is cited as a significant drain on the Kids Place Director's time and energy.

Inclusive, non-categorical settings for services

Kids Place was designed to be a comprehensive parent-child development center to serve the needs of all young children in Scott county. Kids Place houses the county's first licensed child care program and is used by families from a range of income levels, some paying full charges and others subsidized. All children, including those with special needs and those eligible for Head Start, are fully integrated into the child care programs at Kids Place, and therapies are largely classroom-based. The facility contains a preschool enrichment program for children ages 2-5 that incudes two integrated "high-risk toddler classrooms" which serve children enrolled in Part H two days a week. The rest of the week, parents works with the child at home.

Professional development opportunities

The programs that are a part of the Kids Place service system enjoy a relatively stable staffing pattern. The highest staff turnover rate is 10 percent for the child care center and early intervention programs, a rate that is quite low when compared to the national norms. Most of the turnover is among part-time day care staff and therapists for whom the service demand is so great that they leave Kids Place employment to contract their services to other providers.

Within Scott county, professional development opportunities tend to vary among agencies according to the linkages forged between programs (for example, Head Start and private medical providers) or the resources within the agency.

The New Hope Services staff and resource parents at Kids Place can take advantage of a mix of professional development opportunities. They include pre-service courses; a week of workshop activities before school starts; in-service training; tuition assistance up to $150 per semester; and attendance at state and national conferences. Kids Place staff provide training to other local programs and provide internships for students from the University of Louisville, Indiana University, Purdue and Ball State Universities. Interns include nursing, social work, and special education students. Care coordination training is provided in accordance with state guidelines for the WIC program and MCH staff. Other staff have received care coordination training through New Hope Services and the health department.

Head Start provides ongoing training opportunities for staff. Teaching staff are given 100 percent assistance in obtaining the CDA credential, and tuition assistance for post-secondary-related courses is available to all staff.

More recently, the State Step Ahead program has entered into an agreement with the McDonald's Corporation to train people to serve as CDA advisors. A grant from Ronald McDonald Children's Charities will be used to train advisors, who will in

turn, work with other child care providers to help them obtain certification. Advisor-trainees will be drawn from each of the state's nine service areas. Each advisor-trainee will sponsor a candidate for the CDA Credential as part of his or her training. Grant funds will be used for tuition, instructional materials, organization of the classes, travel, monitoring, individual assessments of progress, and liaison with the Child Development Associate National Credentialling Program. Scott County has participants in this program.

Commitment to family support and leadership

The New Hope Services programs located at Kids Place have a strong parent education component and a wide range of services and supports for parents. New parents from high-risk homes typically begin their involvement with individual training sessions in their own homes or participation in a parent-infant play group. They then become part of other center-based parent group activities and finally may become resource parents to other parents. Resource parents provide leadership in the parent support groups and work with the staff parent coordinators on family outreach activities.

Insights on community services from a family perspective were provided to the case study team by mothers who were members of the Kids Place weekly parent support group. Parents' concerns about health care are reflected in the discussion of health care issues in Part One. Parents described access to mental health and housing services as difficult and said they must often rely on Kids Place to intervene on their behalf. The parents interviewed seemed to see themselves as recipients of services and supports from Kids Place and as a parent resource to other parents, rather than as planners, evaluators, or leaders in the provision of services. Although parents are members of the Parent Council for Head Start and the Parent Advisory Committee for First Steps, parents in the 0-2 programs generally do not appear to be active in advocacy-oriented roles. However, New Hope Services has a tradition of hiring parents for staff positions, thus not only providing a parent perspective to service provision, but also using parents as trainers of professionals.

CRITICAL ISSUES REFLECTED IN SCOTT COUNTY

Linkages across a range of levels of care and service system needs

The agencies located in the Kids Place facility work together to provide a strong system of early childhood intervention and prevention services for families in the county. The group of professionals, community leaders and ordinary citizens who organized to address specific needs and who were able to produce the Kids Place building has had a significant impact on this community. The building presents a positive image of what the community can do for itself. Because of the program's strong image and powerful connections in the community, the staff have been able to achieve a high level of collaboration with the Division of Family and Children Services (child protective services is described as "now working hand in glove with us....when before we used to fight and fuss"); education, (especially the teen parenting programs); special needs preschool; and the mental health programs. Some community

leaders credit Kids Place and its positive public image as a factor in the stabilization of the local economy and a small growth spurt in small businesses.

Linkages with Head Start are also worth noting. Although in Scott County the Head Start program does not provide direct services to children birth to three, Head Start (as described above) serves preschoolers through Kids Place and is a member of the Step Ahead Council. As a regional program with an established network of linkages with providers in several counties, Head Start provides benefits to families with infants and toddlers, as well as preschoolers. Head Start family service coordinators and teaching staff make home visits to complete family assessments. These contacts often result in referrals to WIC, child care providers, private and public health care providers, and Child Protective Services. At the administrative level, Head Start collaborates with WIC, Child Protective Services, and private practitioners to organize staff training, and arranges van routes to accommodate children whose Head Start experience is supplemented by other child care programs.

The weakest link in the service system for Scott County's young children and families is health care. The County has no pediatrician, no obstetrician, and no prenatal clinic. Residents may go to a neighboring county for some of these services or to Louisville, Kentucky, 35 miles away. The Well Child Clinic at Kids Place provides health supervision. When acute care is needed, however, only a few physicians in the county will accept Medicaid patients and their caseloads are all "full." Therefore, many families covered by Medicaid use the emergency room at the small local hospital for care.

Health care providers in the county, inspired by the Kids Place model, are now working to create a stronger health care system. The best example of this effort is the collaboration around the Women's Health Clinic. The proposed clinic would provide prenatal and OB-GYN care, with special health services for older women. The hospital administrator has become a more visible presence in the community and the hospital is now doing more outreach through Health Fairs and health education programs. As one interviewee observed, "Up until a couple of years ago, the hospital and the Health Department were going in different directions, and now (emulating the collaboration modeled by Kids Place) they are marching together."

A linkage that may be taken for granted in rural communities but which would not occur in urban areas occurs between Health Department sanitarians (who issue permits for and monitor septic tanks) and Child Protective Services. As they visit households, sanitarians report situations that are of concern to CPS, whose workers generally respond within a 12-hour period. Following the CPS visit, findings are shared with the public health department, although there is currently no mechanism for joint planning to correct conditions.

State support and encouragement

At the beginning of the case study, state-level support and encouragement for community-level services integration was conceptualized as "state leadership encourag(ing) community initiative and mak(ing) a commitment to using the successful experience of one community as a model for others in the state." The experiences of

Kids Place, Scott County, and the state of Indiana in trying to translate community collaboration for comprehensive, non-categorical services into a statewide initiative suggest how complex this process is.

The Scott County perspective on the conceptualization and implementation of Indiana's Step Ahead initiative has contributed significantly to the case study team's appreciation of two critical issues that must be addressed in order to support and sustain successful community-based efforts: 1) the complexity of systems development at the community level, including stages and the phenomenon of "spiraling back"; and 2) the role of leadership and support for community efforts, at national, state, and local levels, including enabling legislation, funding, and other incentives and rewards. As has been emphasized repeatedly in this report, both in the case study analysis and in community descriptions, all services integration efforts are "works in progress." Factors that seem certain to derail that progress may be overcome, and/or new challenges may arise. Thus, while specific issues related to state support and encouragement which were of concern to Scott County interviewees during the case study period may or may not have been resolved by the time this document is being read, underlying questions about, for example, universal vs. targeted services and flexibility vs. accountability, will continue to challenge local communities, states, and the country as a whole.

Scott County interviewees acknowledge that the Kids Place concept of community collaboration and accessible, comprehensive services for children and families in a non-categorical setting evoked a great deal of interest from state agency personnel in Indiana. The process of local planning that created Kids Place was seen as a model for the statewide Step Ahead initiative, which mandates that each county establish a local council for planning children's services. The "one stop shopping" service delivery model was encouraged at the state-level. The Indiana Department of Commerce, for example, allowed small, economically struggling communities to apply for "Community Focus Funds" to build child care centers that could incorporate multiple services. As a result, Scottsburg's Kids Place has been joined by Kids Station, Kids Square, and KidsVille in nearby small Indiana communities.

As the case study was concluding, however, Scott County interviewees observed that state actions were not, in fact, making the Kids Place model more accessible to other communities. Instead, they believed that "replication and even survival is becoming more of a challenge even within the Kids Place system." They identified three issues as problematic, particularly for rural communities.

- Step Ahead's "topdown mandate for collaboration," seen initially as encouraging a spirit of cooperation in communities was accompanied by such a "barrage of policies, fiscal responsibilities, and official guidelines" that local councils were overwhelmed with paperwork, and local creativity and initiative were depleted. Consumer representatives (who, Scott County interviewees noted, were important players in the creation of Kids Place) were "scared away" by "mountains of paperwork and jargon related to multiple funding decisions."

• Communities' flexibility in serving children and families at risk is being eroded by state-defined eligibility requirements tied to increasingly categorical funding. In the past, Scott County interviewees noted, block grant funding allowed local service providers considerable discretion in using funds both for intervention and prevention, and local tax dollars and foundation grants provided a broad base for comprehensive services. State policies that require sliding fee scale participation by families or "scatter" children and families at risk among a range of programs, each with its own eligibility criteria, may be at odds with communities' values, traditions, and successful experiences.

• A proposed statewide system of independent service coordination and multiple voucher system was seen by Scott County interviewees as possibly of merit in metropolitan areas but as operating in small, rural communities as "one more barrier for families and engender(ing) inevitable competition among providers..." An interviewee observed that "the success of Kids Place is that it is accessible, responsive, and relationship-based. Families can access a broad service system through any of the agencies located there by simply walking through the front door. With independent service coordination, that door will have to be closed to families who have not first gone elsewhere to ensure eligibility and be issued vouchers."

A final comment by a Scott County interviewee suggests one answer to the central case study question, "Why is services integration so hard?," and also reflects the determination seen in many leaders in the case study communities:

> We do have persistence and determination to try to make programs work for families in spite of the constant upheavals and new directives from the state-level, but it truly does take a toll. Quality of programming is affected when providers feel discounted and unvalued... True partnerships must exist between families, providers, and policymakers.

COMMUNITY SYSTEM FOR FAMILIES WITH YOUNG CHILDREN
SCOTT COUNTY, INDIANA

STATE PLANNING BODIES

- STEP AHEAD PANEL
  - Step Ahead Advisory Council
  - State Interagency Coordinating Council on Infants & Toddlers
  - Kitchen Cabinet

KIDS PLACE FACILITY

HEALTH

- New Hope Services (NHS)
  - First Steps (FS)
    - -- Welcome Baby Basket Program (WBBP)
  - Teen Parent Services (TPS)
- Scott County Health Dept
  - Well Child Clinic
    - -- EPSDT
  - Immunization Clinic
  - WIC

FAMILY SUPPORT

- New Hope Services
  - First Steps Infant Toddler Intervention Program
    - -- WBB Program
  - Teen Parent Services
- WIC
- Dept of Human Services (DHS)
  - Child Protective Services (CPS)
    - -- Family Support

EARLY INTERVENTION/PRESCHOOL

- New Hope Services
  - First Steps
    - -- Homestart
- Public Schools
  - Special Needs Part-B Program
  - Head Start

CHILD CARE

- New Hope Services
- Division of Family & Children (DFC)
  - Child Protective Services
    - -- Child Care
  - AFDC
  - Medicaid

Private Provider Child Care

Church-based	Business
• First Christian/ Methodist	• CAP • K-CORD

LOCAL PLANNING BODIES

- STEP AHEAD COUNCIL
  - First Steps Advisory Council

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SCOTT COUNTY DEMOGRAPHIC PROFILE

TOTAL POPULATION	STATE	COMMUNITY
• total population	5,544,159	20,991
• African-American	8 %	< 1 %
• American Indian	< 1 %	< 1 %
• Asian	< 1 %	< 1 %
• Caucasian	90 %	99 %
• Latino	1 %	< 1 %
• Other	< 1 %	< 1 %
• below poverty level	10.6 %	19.0 %
• unemployed	5.3 %	7.1 %
• Medicaid recipients	4.9 %	9.3 %
• WIC recipients	3.4 %	7.5 %
• high school grads	38.2 %	38.5 %
• Live births - all ages	15.5 %	15.7 %
• Live births maternal age <18 years	13.8 %	13.6 %
• Low birth weight	6.6 %	6.4 %
• Infant mortality	9.6/1000	6.1/1000

LOCAL SERVICE SYSTEM PROFILE	LIAISON PROGRAM	COMMUNITY SERVICE SYSTEM
• total 0-3 served	120	900
• of 0-3 served, % poverty level	60 %	72.7 %
• total direct service staff	10	20
• bilingual staff & sign language	0	0
• total ethnic minority staff	0	0
• total staff live in community	5	15

The information presented here represents data from 1990. See Appendix B: Community Case Study Issues for discussion of accessibility of statistical data and its implications for service planning and delivery.

Figure 2

Chart I	Major Funding Source	Universal Access 0-3	Ease of Access	Cultural Inclusive	Center or Home Base	# Indiv Served 1990	Referral Follow up	Training Type	Training Hours	Staff Turnover	Parent Involvmnt	Eval.
Prenatal Hlth Svcs.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Perinatal Svcs.	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Teen Preg. Prog.	a	yes	a,b,g	a,c,d	both	35	yes	a,b	b	0	a,b,c,d	a,b
Childbirth Educ.	a	yes	a,b,g	a,c,d	center	10	yes	a	a	0	c	b
WIC Program	d	yes	a,b,g	a,c,d	center	1569	yes	a,b	b	0	c	a,d
Head Start	e	yes	a,c,d,f,g	a,b,c,d	c	158	yes	a,b,c	d	4%	a,b,c,d,e,f,g	f,h
Primary Hlth. Care	c,d	yes	a,b,g	a,c,d	center	420	yes	a,b	b	20%	g	c,d
Immunization	c,d	yes	a,g	a,c,d	center	1000	yes	a,b	b	0	g	c,d
Parenting Instruction	a,d	yes	a,b,d f,g,h	a,c,d	both	60	yes	a,b	b	0	a,b,c,d e,f	a,b
High Risk Registry	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Inf/Tod.Dev. Screening	d	yes	a,b,d f,g,h	a,c,d	both	90	yes	a,b	b	0	a	b,d
Tracking System	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Child Care	a,d	yes	a,g,h	a,c,d	center	26	yes	a,b	b	6%	d,f	a,b
Early Intervention Infants	a,d	yes	a,b,e,h	a,b,c d	both	90	yes	a,b	b	0	a,b,c,d e,f	a,b,d
Toddlers	a,d	yes	a,b,e,h	a,b,c,d	both	90	yes	a,b	b	0	a,b,c,d e,f	a,b,d

KEY

Major Funding Source

a private
b public: local
c public: county
d public: state
e federal
f client fees
g 3rd party
h other

Ease of Access

a central geographical location
b flexible hours of service
c accessible to public transportation
d transportation provided for the disabled
e transportation universally provided
f bilingual staff (including for hearing impaired)
g wheelchair accessible
h waiting lists monitored and updated
j other

Cultural Inclusiveness

a population served is culturally and/or economically reflective of the population in need of services
b public awareness campaigns target diverse groups
c staff reflect the diversity of the population serviced
d use culturally appropriate/sensitive assessment tools

Training Type

a content that focuses on assessing children, working with individuals or families
b content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c other (specify)

Training Hours

a 8-20 hours
b 20-40 hours
c 40-80 hours
d 80 + hours

Parent Involvement

a as member of child's staffing team
b in support groups
c in parenting classes
d on advisory committees
e as board member
f as staff
g other

Evaluation

a self administered
b parent agency administered
c county administered
d state administered
e federal
f all of the above
g other_____specify
h parents are a part of the evaluation team

n/a = not applicable

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Figure 3

Chart II	Major Funding Source	Universal Access	Recruitmt Enrollmt Type	Services Offerred	Ease of Acces s	# Indiv. Served 1990	Referral w/ Followup	Family Needs Assessmt	Indiv. Svcs.	Group Svcs.	Support Groups	Cultural Inclusive	Training Type	Training Hours
GED Classes	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Employment Counseling & Placement	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Housing Assistance	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Financial Assistance (Medicaid; AFDC; SSI)	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mental Health Evaluation & Referral	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Substance Abuse Treatment	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Child Abuse Prevention & Detection Program	n/a	n/a	n/a	yes	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

KEY

Major Funding Source

a	private	e	federal		
b	public:local	f	client participant fees		
c	public county	g	3rd party payment		
d	public state	h	other		

Recruitment/Enrollment Type

a	self referral
b	referrals from other programs
c	outreach from this program
d	other

Services Offered

a	Direct services
b	Screening/assessment
c	Referal for other services
d	Other

Ease of Access

a	Central geographical location	f	Bilingual staff (including for hearing impaired)
b	Flexible hours of service	g	Wheelchair accessible
c	Accessible to public transportation	h	Waiting lists monitored and updated
d	Transportation provided for the disabled	i	Other
e	Transportation universally provided		

Cultural Inclusiveness

a	population served in culturally and or economically reflective of the population in need of services
b	public awareness campaigns target diverse groups
c	staff reflect the diversity of the population serviced
d	use culturally appropriate/sensitive assessment tools

Training Type

a	content that focuses on assessing children, working with individuals or families
b	content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c	other (specify)

Training Hours

a	8-20 hours
b	20-40 hours
c	40-80 hours
d	80+ hours

n/a = not applicable

Figure 4

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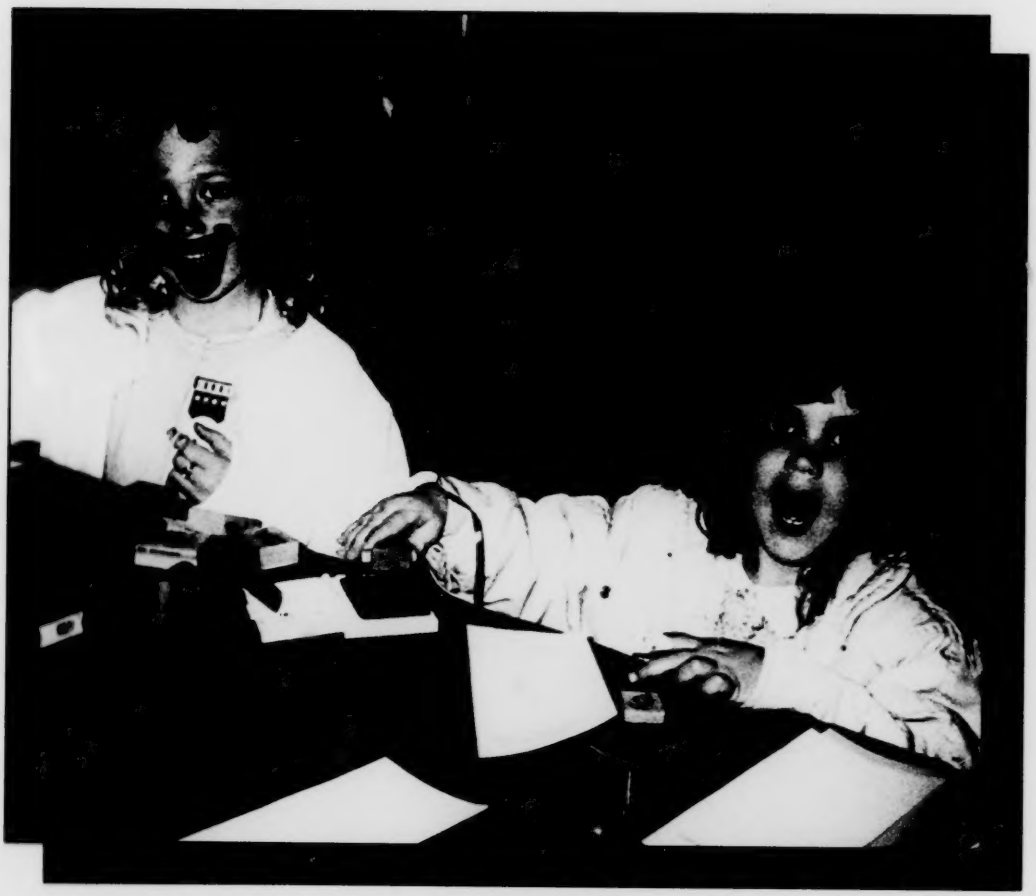
KENT COUNTY, RHODE ISLAND



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KENT COUNTY, RHODE ISLAND

DEMOGRAPHIC PROFILE

Kent County, Rhode Island, includes a mixture of urban, rural and suburban communities. The five towns and cities in the county together have a population of approximately 161,000. Along the highway to Providence, the state capital, are businesses, stores, and restaurants. Service programs tend to be nestled in wooded, residential settings.

At the beginning of the case study, Kent County's population was described as "primarily working class" with "one pocket of high income." About 10 percent of residents are classified as ethnic minorities; Hispanics/Latinos constitute the largest bloc within this group. 1990 census data reports cite a county unemployment rate of 6.3 percent, a low birthweight rate of 8.7 percent, and an infant mortality rate of 5.9 per thousand live births.

At the time of the case study team's 1990 site visit, almost 90 percent of residents had private health insurance and an additional 2.5 percent of children and families were covered by Medicaid. The rate of private insurance coverage has been cited as a major factor in the county's high rates of early prenatal care -- 83 percent of pregnant women enter prenatal care during their first trimester. (However, among pregnant women using Title V [public] prenatal services, 60 percent enter into prenatal care after the first trimester.)

Most county services for infants, toddlers and their families are in the City of Warwick. Located nine miles from Providence, with a population of 88,000, Warwick is a suburban, middle class community. It has 12 elementary schools, six junior and senior high schools, a vocational/technical facility, and a branch of Rhode Island Community College. Warwick is the home of the Kent County Memorial Hospital and five other health care facilities, including Kent County Mental Health Center.

During the course of the case study, programs serving Kent County also began working in the city of Cranston, in neighboring Providence County. Cranston has a substantial Portuguese-speaking population and an increasing number of residents from Southeast Asia.

HISTORICAL OVERVIEW OF THE SERVICE SYSTEM

In 1989, when the Promoting Success in Zero to Three Project began, Kent County enjoyed a reputation as a stable political, economic and social environment that was supportive of family-oriented services. It was described as having a "good network of community planners....and a long history of individual social service programs working together." Its history includes a mandate for preschool services in 1963 and a collaborative planning relationship between Head Start and the education system since 1973. The Head Start program in the city of Warwick was one of the first in the country.

Early Intervention (EI) services have existed in Rhode Island since 1973, when the state legislature mandated services for Children with Special Health Care Needs (CSHCN) through the Department of Mental Health and Mental Retardation. The EI program was designed to accommodate referrals from the Child Development Clinic at Rhode Island Hospital (which was the only resource for developmental evaluations at the time) and from private pediatricians. The legislation's requirement that public health nurses provide two home visits a month to families involved in early intervention established a relationship between the Visiting Nurses Association (VNA) and Early Intervention services. In 1984, state planning grants expanded the programs, and after passage of P.L. 99-457, early intervention services became a line item in the state budget. A program called Child Find, targeting children birth to three, was the predecessor of the current Child Outreach program; it was a year-round effort funded through the Department of Special Education and staffed by "an extended cadre of social workers and psychologists." The state's commitment to early childhood was also reflected in the establishment in Kent County of licensed infant child care programs in local high schools and a high rate of state reimbursement for infant day care generally.

As programs became established in the mid-1980's, early childhood advocates were beginning to explore ways to more effectively coordinate services to families at the local level. This group, described by several interviewees as "natural leaders," included local early childhood and health care providers, professionals in education and human services, and local elected officials. These planners were seeing evidence of some conflict between the tradition of heavy reliance on the private provider community for health care services and the expectations emerging from new initiatives such as P.L. 99-457 for community-oriented services. The City of Warwick was selected as a model site to implement the Family Outreach Program, "an interagency agreement process for linking family information and service needs with community-based agencies."

As the 1980's came to an end, Rhode Island began to experience dramatic economic and political changes. A major banking crisis and loss of related industries reduced both economic and political support for state and local programs that serve families and children. When the case study team visited Kent County in Fall, 1991, the economic base of this community was described as "shrinking." Major manufacturers such as Leesona, Electric Boat and Levita were laying workers off and many retail stores ("even in new shopping malls") were closing. A parent who was interviewed was able to name two neighbors and two friends who had been laid off recently. When asked for examples of things in which the community took pride, respondents frequently cited "independence" as well as the esteem tied to employment. However, the discussion would then quickly turn to community dissatisfaction with the Governor, the Mayor, and the state's overdevelopment in the 1980's, which they blamed for some of the current economic decline.

For two years in a row, Warwick residents voted down a bond issue for roads, sewers, and a firehouse. Voters refused to support a teachers' strike because the issues involved a salary increase and co-payment of health insurance. Cutbacks were made in some services to families, and planned new initiatives were delayed.

By the time of the case study team's 1993 visit to Kent County, however, programs serving families with young children had managed to salvage a major component of the Family Outreach Program. As of 1993, the Family Outreach Program, supported by Part H and Handicapped Children Early Education Program (HCEEP) funds, had become a universal system to identify health, educational and social service needs for all families with infants and toddlers, as well as a system that ensures linkages with appropriate community-based programs. Primary affiliates include the health care community, an early intervention site, and family and center-based child care environments.

CURRENT SERVICE SYSTEM

The system of services for families with young children in Kent County is portrayed in Figures 1 through 4 at the end of this section. Not surprisingly, as programs become more comprehensive, they become less easy to categorize as "disability-oriented" or "health-centered." The Family Outreach Program and the West Warwick Community Health Center illustrate this phenomenon.

The Family Outreach Program

This Family Outreach Program is a group of services including the Infant/toddler Developmental Screening and Tracking System operated by the Kent County Visiting Nurses Association (VNA) and administered by the State Health Department; the Central Region Early Intervention Program, also administered by the State Health Department; and the Local Education Agencies for five cities and towns in Kent County.

- **Developmental screening and tracking**, under supervision of the VNA, begins with a review by public health nurses of birth certificates and other hospital records for all babies born in hospitals in the state. Those determined to be at high risk because of disabilities identified at birth or indicators of family vulnerability receive, with parental permission, a screening that includes: review of pre-natal data (or lack of it), Apgar scores, hours in crisis nursery, demographics and, if indicated, records of the Department of Family Services. Follow-up contacts begin ten days to two weeks following discharge and include home visits by the visiting nurse and a subsequent telephone contact two weeks later. Follow-up may also include a postpartum nursing assessment of mother and child.

- **The Central Region Early Intervention Program**, which has served children and families in Warwick, West Warwick, Coventry, Cranston, West Greenwich and East Greenwich since 1972, uses a transdisciplinary approach to providing family assessments, team evaluations, developmental monitoring, service coordination and management, an integrated day care program, consultation to community day care programs, a center-based developmental/educational group for children with special needs, parent/child groups, support for siblings, and parent education, support, and guidance groups. The program also has a lending library for toys, materials and equipment.

• **The Warwick Local Education Agency (LEA)** collaborates with the Early Intervention system to provide transition services. The LEA provides Child Outreach Transition Services and Special Education Preschool Services which begin when the child is 30 months old. The LEA also assigns personnel to participate in interagency meetings and case staffings.

The Visiting Nurses Association and the Early Intervention programs operate with a combined annual budget of approximately $573,000. State funds supply about 75 percent of this sum, federal funds about 25 percent, and combined municipal and United Way Funds less than one percent. Twenty-three people staff the combined VNA Tracking and Screening system and the Early Intervention program. These two programs and the Warwick Local Education Agency (LEA) served a total of 1,588 infants and toddlers in 1990.

The Dr. John A. Ferris Community Health Center, West Warwick

The West Warwick Center is a federally qualified health center (FQHC) which offers general medical care, prenatal care, pediatrics, family planning, and optometry and podiatry services. Funding comes from the Robert Wood Johnson Foundation, payments from Medicaid and private insurers, state MCH grants, state and municipal allocations, and patient fees (on a sliding scale). The Center employs two full-time physicians, two full-time nurses, two part-time nurses, and a social worker; it contracts with a family practitioner and an obstetrician/gynecologist. A WIC worker is on-site. One physician and a receptionist are bilingual, accommodating growing numbers of Asian and Spanish-speaking families.

The Center provides primary health care to about 100 children ages from birth to age six. The health center also offers child care in conjunction with its parenting programs, prenatal educational program, and nutrition training program for parents.

COMMUNITY SELECTION CRITERIA AS REFLECTED IN KENT COUNTY

Universal access to services

Kent County is one of the two study communities in which developmental screening is universally available. Rhode Island's system for screening birth certificates and other hospital records for all newborns does not require parental consent. The VNA has a policy that makes screening services available to all neonates at the county hospitals. The screening process originally targeted "risk-positive families"; in addition, it now seeks to identify "risk-suspect families" -- those with only a single area of vulnerability as defined by the state Part H program. These areas include child-centered conditions (e.g., NICU stay greater than 72 hours, failure to thrive, and prenatal substance exposure) and "parent-centered" conditions (e.g., chronic illness, parental age of less than 18 years, history of mental disabilities, or history of child abuse/neglect). Families are referred to categorical service programs for which they qualify -- for example, Early Start (for AFDC families only); the Cranston Parent Child Center; the Parents As Teachers program; and the Adolescent Parenting Program.

A screening service is also available to any child referred via the well-child system or self-referral, but participation rates are higher for those identified through birth certificates. An administrator in the Department of Children Youth and Families observed that children who were not born in the county may not be getting the services they need because caseworkers are not well-informed about early intervention services and consequently do not make referrals or encourage families to participate. In addition, low-income and minority families who have been identified through screening may not follow through on referrals if they distrust public agencies.

In Kent County, most early intervention services are provided Monday through Friday, daytime and evenings; VNA services for developmental screenings and home visits for all services are available on evenings and weekends. Limited public transportation in the county poses a barrier to access. Parents are currently trying to organize a van system to improve access for families. To improve public awareness of available early intervention services, the Family Outreach Program has developed a series of brochures in English, Spanish, Portuguese, and Hmong.

Inclusive, non-categorical settings for services

Toddlers in the early intervention program are currently integrated/mainstreamed in some child care and play groups. Usually the child with a disability is placed in a play setting for typically developing children for two and one-half days a week. Child care supported by DCYF funds is in integrated settings.

Professional development opportunities

When the Family Outreach Program was initiated, staff development was an integral part of the design. Training was provided in redesign of services, assessment, transdisciplinary models, and family-centered services, especially for the early intervention program staff. Economic reversals have meant more reliance on state and regional conferences and multi-agency shared training. However, agency-sponsored tuition assistance is still available for both VNA and Early Intervention program staff, and a consultant was recently engaged by VNA to examine staff development issues.

The case coordinator (case manager) interviewed for this study cited a need for standards for case management service, supervision and training specific to case management, and opportunities for peer sharing and networking. She felt that the increase in multirisk families being served by various agencies warranted increased formal training in case management issues.

Commitment to family support and leadership

Kent County presents the strongest example among the study communities of parents who started out in parent support groups and parent education activities and evolved into advocates and activists at the community and state-level. Parents who participated in focus groups during case study team site visits, as well as individual interviewees and Kent County parents in the National Parent Policy Advisory Group, tended to be middle class, with children with special needs. Many of the parents interviewed had been among those who in 1991 succeeded in getting funds for early

intervention services restored to the state budget and have since become part of a statewide network of Parent Action Committees, including the Rhode Island Disability Rights Coalition and a regional organization called The Early Intervention Parent Network.

Parents are involved at all levels of service, producing newsletters and manuals, serving as trainers and leaders on the Interagency Review Committee (the Kent County version of a local Interagency Coordinating Council), and developing interagency agreements. For three years in a row parents have conducted an outreach fair, "A Family Affair," designed to provide information on services to the community at large. There has been a steady increase in attendance and in the cultural diversity of participants at each fair.

The Kent County parents interviewed by the case study team expressed a great deal of satisfaction in their relationship with the Family Outreach Program. Several had children who were now in the school system pre-school program. They indicated that public school staff do not demonstrate the quality of support for parent involvement that they experienced in the Early Intervention system. They indicated that they plan to use the skills developed through the EI program to raise the consciousness of school system personnel regarding parent involvement.

CRITICAL ISSUES REFLECTED IN KENT COUNTY

Linkages across a range of levels of care and service system needs

'Kent County providers, advocates and parents remain committed to the community-wide system that was started in 1989-90. Although the economy has declined and the service system has experienced some loss of political support, agencies maintained the linkage process that had already begun. One provider says that "we were just beginning to work it out (collaboration) when the economic crisis occurred."

The Interagency Review Committee (IRC), composed of middle-managers of community agencies and parents, meets regularly to discuss service and coordination concerns and is generally perceived as a key resource for collaboration, planning and coordination of services. The case manager who was interviewed for this study described the community's system of care as a collaborative process that is facilitated by both a system of planning meetings for agency administrators and informal arrangements among people who share common goals.

One parent who was interviewed described the Interagency Review Committee as the primary facilitator of collaboration, citing it as the "place where the problems of one agency becomes everybody's problem to try to solve." Interviewees agreed that because funding for various local programs comes from separate state agencies, which tend to function very independently, there are occasional coordination problems that could be interpreted as "turfism conflicts." However, potential tensions are lessened and/or resolved by the active participation of parents in the IRC. One agency administrator observed, "It's the families that tie all of the components together." Another administrator noted that the IRC works very well to resolve specific

policy/administrative problems and that "as it works, families receive a consistent message. People on the IRC tend to trust each other because they know each other's programs." The linkage is strongest between direct service providers in the family support and early intervention programs. Administrators for the programs participate with varying degrees of consistency on the IRC. Health care providers and administrators continue to be the weakest link in the collaborative process.

According to the administrator of the Visiting Nurses Association (VNA), one-to-one, face-to-face networking remains VNA's best strategy for improving linkages. She observes, "The family outreach model was designed with this in mind. Early on, it was the most important thing we did; as the system was expanded this has been harder to maintain." Currently, VNA commits one-half day per week of each staff member's time to developing and maintaining connections. Since staff can be reimbursed by third party payers only for direct contacts with children and families, costs for maintaining and improving linkages must be absorbed by the agency.

A state agency interviewee praised the collaboration between Kent County's IRC under the Part H program and the local Coordinating Committee for the Child and Adolescent Service System Program (CASSP) of the Substance Abuse and Mental Health Services Administration (SAMHSA). In an effort to deal with the problem of "too many committees with competing priorities," the two programs have combined their planning bodies and developed a joint mission statement and set of guiding principles. This effort was described as "a demonstration of moving away from the idealistic principles of collaboration toward a realistic approach to linking services." The statement of principles has been distributed throughout the state as a model to be used by other communities.

State support and encouragement

At the beginning of the case study period, Kent County's service system enjoyed strong support from both state agencies and the political/legislative leadership. In fact, Kent County was seen as a model which the state would analyze and replicate. When key elected officials left office, however, there was some uncertainty about the amount of support that would be available in the near future or long term. The VNA representative of the community planning group worked to maintain relations with remaining state-level supporters and cultivate support from newly elected state officials and state agency staffs. One strategy that she used was to continue to make the service linkages developed in Kent County available as a resource to state agencies for collecting data, and for reviewing and commenting on state plans. Parent advocacy efforts at the state-level also is credited with creating visibility for early intervention services and sustained, even increased, support for local programs.

Recent evidence of state support for Kent County's approach to services integration includes: (1) transfer of the EI program to the Health Department to facilitate service integration; and (2) establishment of a committee to explore strategies for increased reimbursement from private insurers for EI services. The best example of state support and confidence in the Family Outreach Program is a recent decision by the state to assign implementation of the statewide neonatal screening process to the Kent County Family Outreach Program. As one interviewee observed, Kent County

VNA was able to have their program "up and running in eight hospitals in 90 days" (while the State Health Department had been trying to implement a statewide system for five years).

The success of Kent County's Family Outreach program has served as an incentive to state-level staff who are trying to promote collaboration among state agencies. A theme that ran through comments of state-level interviewees was the realization of the tremendous challenge that is encountered in trying to integrate services at the state-level. One state agency interviewee also expressed concern that not enough attention has been directed to the fact that there are very few incentives for local level planners to commit the time required for successful collaborative efforts. She noted, "There are not enough reinforcements.. We pay no attention to the psychological stress on community level planners/providers in trying to make this stuff work."

During the period of the case study two state-level planning bodies in Rhode Island were committed to early childhood services -- the Children's Cabinet and the Pew Charitable Trusts' Children's Initiative.

The Children's Cabinet: The Children's Cabinet, chaired by the Director of the State Department of Administration, includes heads of eight state agencies that deal with children and human services. Because Rhode Island has no county-level public agencies, these state agencies have administrative responsibility for service provision at the county/local level. The cabinet, which meets monthly, serves as a forum to discuss common concerns and has the statutory authority to develop a long-term children's plan. According to the chairperson, "The cabinet is working well and beginning to focus on prevention issues, something that has never been adequately addressed before."

At the time of the case study team's 1993 site visit, the Children's Cabinet had produced a five-year plan based on a state-wide inventory of needs and resources, and it had applied for and received a planning grant from the Pew Charitable Trust. A Statewide Governance Organization had been established, comprised of 70 individuals representing state agencies, business and civic organizations, service providers and families.

The Pew Charitable Trusts' Children's Initiative: A strong indicator of state support for early childhood services was Rhode Island's selection as one of five states to receive a $100,000 planning grant under The Pew Charitable Trusts' Children's Initiative. This national initiative was designed to provide selected states with funds and technical assistance, over a period of seven years, to develop comprehensive community-based systems to improve outcomes for children. States that participated in the initiative were expected to ensure that policies, procedures and administrative guidelines associated with funding sources for programs for families with young children emphasized a prevention philosophy and universal access to services. States also were expected to conduct community assessments and develop family centers to provide family-oriented services based on outcome expectations of improved child development and improved family functioning.

The leadership, for the Rhode Island Pew Initiative included a special assistant to the Governor who is widely recognized as an advocate for children's rights; Directors of state agencies for Health; Education; Children, Youth and Families; and Mental Health/Mental Retardation; and a representative from the United Way. Although the Pew Initiative was terminated after the planning phase, collaborative efforts that grew out of it are continuing.

COMMUNITY SYSTEM FOR FAMILIES WITH YOUNG CHILDREN
KENT COUNTY, RHODE ISLAND (w/ Cranston)

STATE LEVEL COMPREHENSIVE POLICY AND PLANNING BODIES
- The Children's Cabinet

State Department of Health

State Department of Education

EARLY CHILDHOOD SERVICES SYSTEM

FAMILY SUPPORT
- Kent County Visiting Nurses Assoc (VNA)
- Cranston Child Development
- Child Inc.
- Dept of Children, Youth & Families
  - Child Abuse & Neglect Tracking System
  - Early Start
  - Even Start
  - Day Care Subsidies
  - Pathways to Independence
  - Direct Services Unit
  - Options for Working Parents
- Family Outreach

HEALTH-CENTERED
- Adolescent Parenting Pregnancy Program
- Cranston Health Center
- John A. Ferris Community Health Center
- WIC

EARLY INTERVENTION/ Disability-Oriented
- Developmental Screening & Tracking Program (VNA)
- Central Region Early Intervention Program
- Community Local Education Agencies
  - Child FIND
  - Child Outreach Transition Services

EARLY CHILDHOOD PLANNING BODIES
- The Interagency Review Committee/ Child and Adolescent Service System Program

State Department of Human Services

Private Health Care Providers

Child Care Services Network

Women's Shelter

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KENT COUNTY DEMOGRAPHIC PROFILE

TOTAL POPULATION	STATE	COMMUNITY
• total population	1,003,464	161,135
• African-American	3 %	< 1 %
• American Indian	< 1 %	< 1 %
• Asian	1.5 %	< 1 %
• Caucasian	90 %	97.5 %
• Latino	3 %	1 %
• Other	2 %	< 1 %
• below poverty level	9.6 %	5.5 %
• unemployed	6.7 %	6.3 %
• Medicaid recipients	3.2 %	2.5 %
• WIC recipients	1.9 %	1.1 %
• high school grads	19.3 %	22.0 %
• Live births - all ages	14.7 %	13.6 %
• Live births maternal age <18 years	15.4 %	11.9 %
• Low birth weight	61.6 %	46.9 %
• Infant mortality	unavailable	5.9/1000 (1991)

LOCAL SERVICE SYSTEM PROFILE	LIAISON PROGRAM	COMMUNITY SERVICE SYSTEM
• total 0-3 served	1,588	not available
• of 0-3 served, % poverty level	not available	not available
• total direct service staff	17	not available
• bilingual staff & sign language	0	not available
• total ethnic minority staff	0	not available
• total staff live in community	6	not available

The information presented here represents data from 1990 and 1991. See Appendix B: Community Case Study Issues for discussion of accessibility of statistical data and its implications for service planning and delivery.

Figure 2

Chart I	Major Funding Source	Universal Access 0-3	Ease of Access	Cultural Inclusve	Center or Home Base	# Indiv Served 1992	Referral Follow up	Training Type	Training Hours	Staff Turnover	Parent Involvmnt	Eval.
Prenatal Hlth Svcs.	d	yes	a,b,e,f	a,b	unavail	unavail	yes	unavail	unavail	unavail	unavail	unavail
Perinatal Svcs.	d,e	no	a,b,e,f	a,b	unavail	unavail	yes	unavail	unavail	unavail	unavail	unavail
Teen Preg. Prog.	e	no	a,b	a,b,c	unavail	unavail	yes	a,b,c	d	10%	unavail	unavail
Childbirth Educ.	a,d	no	a,b,e,f	a	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
WIC Program	d,e	yes	a,b,e,f	a	center	unavail	yes	unavail	unavail	unavail	unavail	unavail
Head Start/PCC	e	yes	a,b,d,f,g	a,b,c,d	c,h	30	yes	a,b	d	40%	a,b,c,d,f	a,b,e,h
Primary Hlth. Care	e,d,g	no	a,b,e,f,g	a,b	unavail	unavail	yes	unavail	unavail	unavail	unavail	unavail
Immunization	d,g	no	a,b,e,f,g	a,b	unavail	unavail	yes	unavail	unavail	unavail	unavail	unavail
Parenting Instruction	d,e,g	no	a,b	a,b,d	unavail	unavail	yes	unavail	unavail	unavail	b,c,d	a,b,d
High Risk Registry	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Inf/Tod.Dev. Screening	d,e	yes	in hospital	a,b,d	home	1478	yes	a,b,c	d	15%	a,d	a,e
Tracking System	d,e	yes	or at home	a,b,d	n/a	1478	yes	a,b	d	25%	d	a,e
Child Care	d,e	no	a,b,g	a,c	unavail	unavail	yes	unavail	unavail	unavail	unavail	unavail
Early Intervention Infants	d	no	a,c,f,g	a,b,d	center home	120	yes	a,b,c	d	20%	a,b,c,d,e,g	b,h
Toddlers	d,e	no	a,c,f,g	a,b,d	C,H	120	yes	a,b,c	d	0%	a,b,c	b,h

KEY

Major Funding Source

- a private
- b public: local
- c public: county
- d public: state
- e federal
- f client fees
- g 3rd party
- h other

Ease of Access

- a central geographical location
- b flexible hours of service
- c accessible to public transportation
- d transportation provided for the disabled
- e transportation universally provided
- f bilingual staff (including for hearing impaired)
- g wheelchair accessible
- h waiting lists monitored and updated
- j other

Cultural Inclusiveness

- a population served is culturally and/or economically reflective of the population in need of services
- b public awareness campaigns target diverse groups
- c staff reflect the diversity of the population serviced
- d use culturally appropriate/sensitive assessment tools

Training Type

- a content that focuses on assessing children, working with individuals or families
- b content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
- c other (specify)

Training Hours

- a 8-20 hours
- b 20-40 hours
- c 40-80 hours
- d 80 + hours

Parent Involvement

- a as member of child's staffing team
- b in support groups
- c in parenting classes
- d on advisory committees
- e as board member
- f as staff
- g other

Evaluation

- a self administered
- b parent agency administered
- c county administered
- d state administered
- e federal
- f all of the above
- g other_____specify
- h parents are a part of the evaluation team

n/a = not applicable unavail = unavailable

Figure 3

BEST COPY AVAILABLE

KENT COUNTY, RHODE ISLAND

COMMUNITY SERVICE SYSTEM PROFILE

Chart II	Major Funding Source	Universal Access	Recruitmt Enrollmt Type	Services Offered	Ease of Access	# Indiv. Served 1990	Referral w/ Followup	Family Needs Assessmt	Indiv. Svcs.	Group Svcs.	Support Groups	Cultural Inclusive	Training Type	Training Hours
GED Classes	e	unavail	a,b,c	•	•	•	•	•	•	•	•	•	•	•
Employment Counseling & Placement	d,e	unavail	a,b,c	•	•	•	•	•	•	•	•	•	•	•
Housing Assistance	d,e	unavail	a,b	•	•	•	•	•	•	•	•	•	•	•
Financial Assistance (Medicaid; AFDC; SSI)	d,e	unavail	a,b,c	•	•	•	•	•	•	•	•	•	•	•
Mental Health Evaluation & Referral	d,e,f,g	unavail	a,b	•	•	•	•	•	•	•	•	•	•	•
Substance Abuse Treatment	d,e,g	unavail	a,b,c	•	•	•	•	•	•	•	•	•	•	•
Child Abuse Prevention & Detection Program	d,e	unavail	a,b	•	•	•	•	•	•	•	•	•	•	•

KEY

Major Funding Source

a	private	e	federal
b	public:local	f	client participant fees
c	public county	g	3rd party payment
d	public state	h	other

Recruitment/Enrollment Type

a	self referral
b	referrals from other programs
c	outreach from this program
d	other

Services Offered

a	Direct services
b	Screening/assessment
c	Referral for other services
d	Other

Ease of Access

a	Central geographical location
b	Flexible hours of service
c	Accessible to public transportation
d	Transportation provided for the disabled
e	Transportation universally provided
f	Bilingual staff (including for hearing impaired)
g	Wheelchair accessible
h	Waiting lists monitored and updated
i	Other

Cultural Inclusiveness

a	population served in culturally and or economically reflective of the population in need of services
b	public awareness campaigns target diverse groups
c	staff reflect the diversity of the population serviced
d	use culturally appropriate/sensitive assessment tools

Training Type

a	content that focuses on assessing children, working with individuals or families
b	content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c	other (specify)

Training Hours

a	8-20 hours
b	20-40 hours
c	40-80 hours
d	80+ hours

• = services are not provided; make referrals only

unavail = unavailable

Figure 4

BEST COPY AVAILABLE

TRAVIS COUNTY, TEXAS

BEST COPY AVAILABLE

TRAVIS COUNTY, TEXAS

DEMOGRAPHIC PROFILE

Travis County is located in south central Texas in what has been described as "the heart of the Texas hill country." It is approximately 170 miles from Houston, the state's largest city, and 250 miles from the border of Mexico. The County's population of more than 576,000 residents contains a multicultural mix of families living in rural, suburban, and urban settings. Austin, the state capitol, is the largest city in the county; its 464,00 residents account for more than 80 percent of the county population. One interviewee described Austin as a predominantly liberal community "full of sensitive caring people who are aware of political and social issues,...proud of its cleanliness, lakes, parks and cultural diversity;...a good place to raise children; and where people feel protected because social services are available for those in need."

Travis County is the most ethnically diverse of the six communities in the case study. According to 1990 census data, its population is 65.1 percent Caucasian, 21.1 percent Hispanic/Latino, 10.6 percent African-American, 2.7 percent Asian, and about 2 percent American Indian and "other."

Major employers for the county are government (federal, state, and local); private industry (Lockheed Missiles, Motorola Inc. and IBM); and education (the Austin Independent School District, the University of Texas at Austin, and four local colleges). In 1990, the unemployment rate for Travis County was 6 percent. In both Austin and throughout the county there are pockets of poverty. In 1991, about 20 percent of children from birth to six lived in poverty.

There are six independent school districts in the county and 113 elementary and secondary schools. Although the county's high school drop-out rate is 10 percent (compared to the state rate of 13 percent), tracking of students from the ninth grade on showed a 29.5 percent longitudinal drop out rate in 1990.

The county is served by four hospitals and ten public health clinics. In 1991, 6.2 percent of babies in the county were born at low birthweight, and the infant mortality rate was 7.3. In 1990, the county's rate of births to teens 17 years or younger was 30.4 per thousand; 47 percent of these mothers received late or no pre-natal care.

Austin is typical of many American cities experiencing an increase in substance abuse, violence, and single parent families. One parent who was interviewed described a two-year waiting list for public housing and stated that the laundry room in her public housing complex is closed daily at 5 p.m. due to fears of gang violence. During the case study period, this community experienced a downturn in the economy, with resulting increases in unemployment and homelessness, and a more conservative political climate regarding social programs. In rural areas, the problems are complicated by isolation, and as inner city housing costs have increased, many poorer families are moving to the fringes of the city. This mix of high- and low-resource neighborhoods, common to many urban areas, provides the backdrop for the system of services for families with young children in Travis County.

The neighborhood that serves as the primary consumer of the service system for our case study community is East Austin. East Austin has been described as having a mixture of transients, along with families that have lived there for generations. It is one of the poorest areas in the city, with approximately 35 percent of the residents classified as living below poverty level (80 percent in some census tracts). In East Austin, families experience higher rates of unemployment, violent crime, infant mortality, and high school drop-out than in the rest of the city. It is the most ethnically diverse section of the city and county, with 1980 census tract figures showing 11.9 percent Caucasians, 45.9 percent African-Americans, and 41.8 percent Hispanics/Latinos. Approximately 20 percent of East Austin residents do not speak English. Surveys over the past several years have shown that of the families served by the CEDEN Family Resource Center, 80 percent of the mothers do not have high school diplomas, and currently, 14 percent of the mothers in the Parent-Child program exposed their babies to drugs prenatally. Approximately 28 percent of the families served by the center speak Spanish only; many are new immigrants who usually require a full range of support services.

In spite of these statistics, the East Austin neighborhood was described by one respondent as "...still a well maintained community where citizens take pride" in the landscaping in the area and its proximity to the Colorado river. There are a large number of extended families in or near the community, and certain sections of neighborhoods are settled by people from the same parts of Mexico, usually with a church as the focal point.

HISTORICAL OVERVIEW OF THE SERVICE SYSTEM

The need for services for infants and toddlers with special health care needs and child care for infants has been a concern in this community for several years. Interviewees cited early examples of advocacy in greater Austin on behalf of services for infants and toddlers by the Open Door Preschools and the Mental Health Mental Retardation Infant-Parent Program. The preschools introduced "mainstreaming" and infant care into child care programs and were described by one interviewee as successful in serving a wide range of income and ability groups. The MHMR program has been described as instrumental in introducing child care services as a component of special needs programs.

Recent years have seen increased concern in the county for families with young children. One interviewee described the impact of drive-by shootings, concerns about children in gangs, and seeing "a third generation of families in which a lot has gone wrong" as increasing public recognition of the importance of early intervention. As a result, city and county Social Services and groups such as the United Way began to support prevention initiatives. Specific funds were set aside for prevention -- $400,000 was designated for prevention services targeting infants and children from birth to age 8 and their families in one high-risk neighborhood.

The Interagency Council on Early Children Intervention (ECI)

The present service system for infants and toddlers with special health care needs and their families in Travis County began to evolve in the late 70's and early

80's. In 1981 a group of early childhood professionals organized to hold a series of meetings on services and resources for children with health/disability needs and for at-risk children. Using state health department (MCH) funds, they started the birth-to-three network in the Austin area that eventually evolved into the Central Texas Infant Forum. At the same time, a statewide effort was underway to convince the state legislature to establish legislation and funding for early childhood services for infants and toddlers with special needs. When the legislation was passed in 1981, several million dollars were appropriated for statewide services to infants and toddlers. The new legislation established the Interagency Council on Early Childhood Intervention (ECI). By 1983, program standards had been developed, criteria for new programs were established, and a funding formula of 20 percent local contribution/80 percent state contribution had been established. As a separate state agency, ECI is authorized to present a separate budget to the state budget board and comptroller, and its Director reports to the Interagency Council.

In 1986, with the passage of P.L. 99-457, Part H, the Interagency Council for ECI was designated as the lead agency for Part H. Since ECI became the lead agency for Part H, there has been some narrowing of focus in order to address Part H issues. Currently, Texas ECI services are restricted to children eligible due to specific medical conditions, severity of developmental delay based on a developmental assessment, or atypical development that has been assessed by specific categories of professionals. In addition, the Interagency Council funds transitional services programs as part of the Child Find effort under IDEA.

The CEDEN Family Resource Center

The CEDEN Family Resource Center, located in East Austin, served as the liaison agency for the case study in Travis County. The concept for the CEDEN program originated with its current Director, who recognized the need to target services for the Hispanic/Latino population in East Austin.

CEDEN was started with the formation of a planning/policy board that included a local priest, who offered his church as an office to house the program free of charge, and the head of the Institute of Latin American Studies (ILAS) at the University of Texas. Others who joined in the effort were formal and informal leaders in the Hispanic neighborhood, private physicians, a local school principal and staff, parents, and church leaders. This group of 15-18 members evolved into two groups: a Parent Advisory Board and a Board of Directors.

Early funders were the Hogg Foundation for Mental Health, the Texas Department of Community Affairs, Youth Services Division, the Ford Foundation, and somewhat later, the United Way/Capital Area City of Austin and Travis County. In addition, there were donations of office supplies and furniture from IBM, accounting services from a local CPA, and donations of food and clothing from local religious groups. In 1986, CEDEN began receiving funding from the Interagency Council on ECI, with additional funding from the Children's Trust Fund of Texas (its funding source is the Texas marriage tax, used for preventing abuse and neglect), and the Texas Education Agency (to support the Teen Parenting Program).

Because of population shifts and other funding opportunities, CEDEN now serves families from other ethnic groups and geographical areas, including the Del Valle Independent School District, a community in which 40 percent of the families are connected to the military.

From the beginning, CEDEN was organized to accomplish two main missions: to provide prevention-oriented services to families with small children and to develop culturally-responsive training materials, parent education materials, and evaluation instruments and systems for the Hispanic community. The research and development component of the program was originally ineligible for funding from some potential funding sources. As a result, CEDEN has pursued a strategy of securing diversified funding sources, many of which have roots in the community.

CURRENT SERVICE SYSTEM

Figures 1 through 4 at the end of this section, portray the system of services for families with young children in Travis county at the time of the case study team's site visit in 1993. That system includes ECI-supported services as well as services for children at risk of poor outcomes which are supported by a combination of county, local and private funds. Child care, early intervention, family support, and health care programs are linked to planning bodies and resource and referral programs which target families with young children.

The CEDEN Family Resource Center is described in some detail below in order to offer readers an opportunity to compare and contrast its program design and development with comprehensive programs in other participating communities. Travis County's child care-related services are discussed at some length not only because of their intrinsic interest but also because this community was the only one of the six study communities in which infant/toddler child care was a major context for services integration.

The CEDEN Family Resource Center

The CEDEN Family Resource Center is a research and development center, with programs that are multiculturally derived and bilingual. The center focuses on serving low-income families that may include: young children who are severely, moderately or mildly developmentally delayed or at risk of becoming delayed, abused, or neglected; pregnant and parenting teens and their children; and high-risk pregnant women. The Center offers an array of services for preschoolers, school-age children and their parents. Those programs that target families with infants and toddlers include:

- **The Prenatal Education Program** helps to secure and maintain regular prenatal health care visits and provides high-risk pregnant teens and women with prenatal educational visits; information packets (developed by CEDEN) in Spanish or English; a hospital visit to new mothers with gifts including an instructive infant development book, a layette, and family planning tips; a postnatal educational visit, with a newborn screening; and case management and referrals, as needed.

• **The Parent-Child Program: ECI Services** provides screenings, child and family interdisciplinary assessments, and IFSPs. Services include: parenting classes; a toy lending library; a drop-in center for parents; weekly home visits and monthly support groups; physical, occupational and language therapies; bilingual language development groups and infant stimulation; and health, nutrition and safety education classes. This program is the only service offered by CEDEN that is funded by the state Interagency Council on Early Childhood Intervention.

• **The Parent-Child Program: At-risk and Family Services Program** assists mildly delayed and high-risk children and their parents. This program was developed through special private funding services to provide individualized and case management services to infants and toddlers who were not eligible for ECI-funded services.

• **A Collaborative Parenting Education Program** with the Austin Community Nursery Schools is based in local day care centers in East, North and South Austin. It provides prenatal education services, the full range of Parent-Child Program services (depending upon child and parental needs), and parenting classes, parent support groups and parent involvement groups. Staff also provide in-service training for child care staff.

• **The Teen Parent Program**, initiated with funding from the Texas Education Agency's Parent Involvement Grant to the Del Valle Independent School District, which in turn contracted with CEDEN, provides pregnant and parenting teens with the full range of services required to continue school or return to formal education, as well as learn essential parenting skills. The school district offers free child care, transportation to school, counseling, a competency-based secondary school program, computer skills training, and cooperative summer school and work arrangements. In weekly home visits to teens and their children, CEDEN's Family Development Specialists cover such topics as child development, nutrition, health, and home safety. Parenting classes have also been offered and taught by CEDEN's parent educator. CEDEN also works with out-of-school teens, making referrals to health care, day care, and other resources that can benefit their entire families. In addition to these services, CEDEN provides prenatal education and case management.

CEDEN has also opened a branch office serving more teens in the northwest corridor of Travis County, a central/north office, and a new Healthy and Fair Start Program for Southeast Austin, which combines all preventive services for improving prenatal and postnatal outcomes.

Family support services

In addition to the family support services offered by the CEDEN Center, other providers include:

• **Community Advocates for Teens and Parents (CATP)** provides family planning and an emergency shelter program for 20 teens and their children. Travis County funds a child care program for 12 children of teens that are in CATP's program.

• **Teenage Parent Council** operates two programs, the Adolescent Parenting Program and the Stepping Stone program. The City funds the Adolescent Parenting Program, which facilitates networking of local agencies to support teen parents. The County funds the Stepping Stone program, which provides comprehensive case management for teen parents.

• **Any Baby Can**, funded by the Texas Department of Health, provides identification, information and crisis assistance for families with children birth through age 12 who have chronic illnesses or disabilities. In addition to information and referral services, the program provides short-term counseling and case management services, crisis financial assistance, and items like special formulas and medical equipment to families in crisis situations. Families served include those who self-refer as well as families referred by Child Protective Services because they are deemed at risk of abuse or neglect. The Any Baby Can program, while new to the Austin community, has been serving families in San Antonio, Texas for the past 11 years.

Child-care related services

Until recently, Austin did not have a strong child care system. Child care generally had been supplied by small, for-profit providers, supervised by the Departments of Health and Human Services. Non-profit agencies providing child care included churches and privately-administered, publicly-funded agencies.

In 1989, in response to welfare reform legislation, the Texas Department of Human Services established a Child Care Management System (CCMS). The goal was to channel various federal funding streams for child care so as to provide maximum continuity for children and families. Thus a family who might, over a two-year period, be eligible sequentially for subsidies from the JOBS program, Transitional Child Care, Title IV-A, and the Child Care and Development Block Grant, would not have to change providers as funding sources changed.

Austin Families was designated as the CCMS contractor for the Austin area. Using eight different funding sources, (Title XX; Title IV-E; Title IV-A JOBS, TCC, and At-Risk; Child Care and Development Block Grant [CCDBG]; state General Revenue; and Food Stamp Employment and Training) Austin Families works with local providers of child care and has authority to use CCDBG funds for quality improvement. The organization's child care switchboard, supported by city and county funding and fees on a sliding scale, helps working families find appropriate child care.

Child care services in Austin include:

• **CONNECTIONS**, an early childhood resource center for child care providers and parents, offers a lending library of educational materials, toys and games, information about community resources, training, technical assistance, and parenting classes.

• **Child care for low-income city employees** is subsidized through a city-established voucher program.

• **Child care and development programs** that serve families with infants and toddlers include: Austin Community Nursery Schools' three child care centers; Child, Inc. (Head Start's) comprehensive program for 490 children ages 0-3; Ebenezer Child Development Center's sliding-fee-scale services for children ages six weeks to five years; the Foundation for Texas Children's child care and related services for teen parents; the Open Door Preschools' three child care programs for children ages two months through five years, which are "mainstreamed" for preschoolers; and the "Bridge Program," which places children of homeless and near-homeless families with specially trained providers.

CCMS also supports training for child care providers. Through a contract with Austin Community College's Child Development Department, the City of Austin is enabling staff of child care centers that serve low- and moderate-income families to get individual training, technical assistance, and support to improve the quality of their services. During the first year of this program, five centers received accreditation from the National Academy of Early Childhood Programs; six centers anticipate accreditation after the second year.

COMMUNITY SELECTION CRITERIA AS REFLECTED IN TRAVIS COUNTY

Universal access

All Travis County interviewees see universal access, however defined (comprehensive services available to all families without regard to eligibility guidelines; access for all persons who are eligible for a given service; or services for all families and children at risk of poor outcome) as an ideal that cannot be realized given current funding resources. Respondents offered several examples of current patterns. With respect to health care, the county health department offers well child care and prenatal services to all on a sliding fee basis, but EPSDT can only be accessed by Medicaid-eligible families. While access to child care services has been increased for low-income families, there are still insufficient child care resources for the community as a whole. Programs designed to serve all who need them, such as family support and programs for teen parents, lack the funding to serve all who apply. Within these constraints, however, providers work hard to make available services accessible to families who need them. Strategies for doing so include concentrating services in high-need areas, locating sites for application for multiple benefits throughout poor communities, and making culturally appropriate referrals.

Travis County interviewees described their experience with policies that impede the provision of preventive services to families with young children at risk of developmental problems. CEDEN, as described above, was created to provide preventive services to at-risk families. When ECI became a principal funding source for CEDEN, however, eligibility was restricted to children with "documented delay." In practice, this requirement meant that only 25 percent of young children screened by CEDEN were eligible for ECI-funded services. For more than a year, until funding sources for "at risk services" were found, families that would have been served in the past had to be turned away. Staff implemented an interim (and for them highly distressing) strategy of rescheduling children for assessments at three- or six-month

intervals, on the theory that without intervention, children would begin to show developmental delays sufficient to make them eligible for services according to ECI criteria.

Inclusive, non-categorical settings for services

Child care centers funded by the United Way and local Head Start centers constitute the primary sources of non-categorical services for infants and toddlers. As services and programs have expanded under the Community Child Development Block Grant programs described earlier, inclusion of infants and toddlers into non-categorical programs is increasing. As described above, the CEDEN program provided non-categorical services early in its history, but 1990 ECI guidelines for funding initially reduced CEDEN's capacity to operate as a non-categorical setting. Currently, new sources of support have permitted expansion of CEDEN's services.

Professional development opportunities

Efforts to respond to the generally-acknowledged need for increased training opportunities for child care providers have been described above.

CEDEN provides its staff with biweekly in-service training sessions as well as opportunities to attend professional conferences and workshops. The Central Texas Infant Forum provides training on topics such as IFSP development and assessment techniques. Recognized as a leader in the development of bilingual materials and in serving Hispanic families, CEDEN provides training to others in the community on these topics.

At the state-level, the Head Start Collaboration Project has established a 30-member training committee. This group, in consultation with the Wheelock College Center for Career Development, held a statewide training conference and, in collaboration with the Department of Human Services, contracted with the University of Texas to conduct a statewide survey of child care facilities and personnel. A plan for a statewide personnel preparation system has been developed.

Commitment to family support and leadership

Information on parent involvement, support, and leadership comes from an individual parent interview, the three parents representing the Austin community in the project's National Parent Policy Advisory Group, and a parent focus group convened during the case study team's site visit. All of these parents were recruited by the CEDEN Family Resource Center, our liaison agency. Parents included informants who were very knowledgeable about the complete range of services in the city as well as non-English-speaking recent immigrants whose primary service system contacts were with CEDEN.

All the parents praised the support services provided by CEDEN and voiced a number of complaints regarding other services, especially medical services. Parent complaints were not so much about the lack of services in the community/county, as they were about poor linkage and collaboration. One parent, who was also a foster

parent and a lay minister in the community, described efforts to get services for a child who had been diagnosed as failure to thrive. The child was one of a group of siblings placed with her through the court. She had trouble getting services although all of the children in the family were on Medicaid at the time they were placed with her. She had to reapply three times for Medicaid for them and finally demanded to see the supervisor. She described very poor linkage among agencies, stating that all of the information she had provided to workers at various agencies had to be given repeatedly to each new worker.

Several Spanish-speaking parents complained of agencies that included some Spanish-speaking staff but did not use them effectively. Parents recalled being scheduled repeatedly for appointments on days when Spanish-speaking workers were not in the office; sometimes a Spanish-speaking worker would neglect to ensure that referrals to other agencies were also to workers who spoke Spanish.

The parents indicated that the community as a whole does not do a good job of outreach to parents and parent involvement. CEDEN was given high marks for outreach, especially to Hispanic families, and was described as being very helpful in assessing and working with families, making referrals and follow-up. The parents most closely associated with CEDEN described the parent education groups as particularly helpful (AIDS, budgeting, nutrition, black history). However, they said they were not aware of any parent support groups or leadership development activities for parents. No parents described experiences of leadership in any of the programs or services they used. CEDEN does hire parents whose children have graduated from the program.

Although parents from this program were not interviewed, Child Inc. (Head Start) representatives described their Parent Policy Council, a group composed of one parent representative from each of its 22 centers in the area. The members of the council serve as advisors on budget, program, and policy issues.

CRITICAL ISSUES REFLECTED IN TRAVIS COUNTY

Linkages across a range of levels of care and service system needs

Two types of collaboration and linkage occur within community-based systems: the informal collaboration among direct service providers that is tied to referrals and service coordination and the formal collaboration resulting from joint participation in planning bodies. Within the Travis County early childhood community, informal collaboration and linkage appear to occur more often among programs with similar funding sources and missions (i.e., among ECI-funded programs, or among child care programs), suggesting the influence of categorical funding streams on the collaborative process. More formal linkage and collaboration efforts, such as the Child Care Council and the Child Welfare Board, include a cross-section of agencies as members, but membership may not mean active involvement. Interviewees referred repeatedly to the impact of personality and leadership styles on the collaborative process, especially "across funding streams." Several interviewees stated that while individuals with strong and forceful personalities are often effective in obtaining resources for their constituencies, those same individuals can be difficult to

work with as collaborators in **providing** services. The consensus was that motivation and incentives were stronger for linkages among similar programs (perhaps serving similar families?) than across systems.

A consumer perspective on linkage was offered by a parent who has had extensive experience with a wide range of service programs in the community. Her assessment of the various components of the service system reflected a comprehensive awareness of how the system was supposed to work and what seemed to work best for families with young children. She indicated that local government agencies, such as public health and welfare, had literature available on early childhood programs and other jobs, training, child care, and housing services, and staff would make referrals, but workers had little or no knowledge of what the programs were really about or how they operated. She commented that "help is pretty much available for anyone who wants it and seeks it out" (but services are not always well advertised, promoted, or familiar to staff at various agencies). This parent gave higher marks to the private network of services, especially those in East Austin that are oriented toward the Hispanic community.

All interviewees were able to cite examples of progress in collaboration (CEDEN and the Austin Community Nursery Schools Project, Any Baby Can and ECI-funded programs collaborating on a Respite Care grant application) and expressed a good deal of optimism about the potential of The Community Action Network (CAN), the Austin Project, and state-level initiatives such as the Head Start Collaborative Project for enhancing community-level systems integration efforts. The Austin Project currently has two active groups related to services for young children. The Perinatal Coalition of the Austin Project is addressing issues around improved access to prenatal care and improved birth outcomes. The Immunization/Wellness Task Force is spearheading a campaign to improve the immunization status of the community, with a special emphasis on infants and toddlers. The Child Care Council is working with The Austin Project to establish an Early Care and Education Task Force to develop a comprehensive system of early childhood services for the community.

State support and encouragement

State support for early childhood services is best demonstrated in the way various initiatives are assisted at the community level, mainly through categorical programs. While there has been a history of collaboration among early intervention programs for children with special needs, state-level interviewees indicated that collaboration between other state early childhood programs is in its early stages.

In 1992, the Health and Human Services Commission was created, with representatives from 14 agencies meeting to make policy and funding decisions. The commission has established committees to conduct assessment and planning on issues including data development, rural renewal, and co-location of programs, among others. One outcome of this effort is an agreement between The Bureau of Chronically Ill and Disabled Children (CIDC), Maternal and Child Health (MCH) and ECI on how to determine which program is the comprehensive case manager when a child is served by the three agencies. A memo was developed and disseminated to all agencies and

all workers. An interviewee stated, "This is the first time the state has taken the lead on a joint plan to enhance service provision" and noted that local ECI programs have responded favorably to the new procedures.

As described above, several recent state-level initiatives have been designed to enhance coordination of policies and services for children and families. The Texas Child Care Management System's impact on Austin's child care services has been described earlier. The Head Start Collaboration Project works with the Texas Department of Human Services Welfare Reform Programs and the Texas Education Agencies Preschool Parents Involvement Initiative to improve linkages between local public and private service providers for Head Start-eligible children ages birth through eight and their families. A plan for personnel development will include legislative recommendations for the January, 1995 State Legislative session. The Texas Head Start Collaboration Project has recently been placed within the Health and Human Services Commission.

The relationship between ECI and CEDEN illustrates the possibilities and constraints involved in state agency/community program collaboration, particularly when funding guidelines are shaped by national policies. As described earlier, CEDEN's participation in the ECI system and accompanying funding initially caused some erosion of the prevention services that the Center had originally provided, in favor of early intervention services to ECI-eligible children. However, this challenge encouraged CEDEN to seek new funding for its Teen Parent Program, Parent-Child Program, At-Risk Services, Family Services, Collaborative Parenting Education Program, and Healthy and Fair Start Program. Because of its history of close collaboration and linkage with private health providers and religious leaders in the East Austin community and with the Austin business community, CEDEN is gaining a national reputation for its approach to providing early intervention and prevention services, especially to Hispanic families. Its program is being replicated in six communities in Texas through funding from Children's Trust Fund of Texas, several school districts, the Presbyterian Church, and various foundations.

COMMUNITY SYSTEM FOR FAMILIES WITH YOUNG CHILDREN
TRAVIS COUNTY, TEXAS

CITY-WIDE COMPREHENSIVE POLICY AND PLANNING BODIES
Community Action Network (CAN)
* The Austin Project

Human Service Agencies
- Dept of Health & Human Svcs
  - Child Welfare
  - Child Protective Services
  - City of Austin
  - Children & Youth Planning Svcs

EARLY CHILDHOOD SERVICES SYSTEM

HEALTH SERVICES

- Neonatology Hospital Units
- Pediatric Home Care
- Austin/Travis County's Dept of Health & Human Svcs
  - Well Child
  - People's Community Health Clinic
  - WIC
  - EPSDT
  - Pre Natal
  - Seton Teen Parent Center
- STAR Initiative PPO, PCA, VISTA

CHILD CARE

- City/County Funded
  - Austin Community Nursery Schools
  - Child Inc/Head Start
  - Ebenezer Child Development Center
  - Bridge Voucher Prog
  - Open Door Preschool
- Privately Funded/Operated
- ACC Laboratory School
- State Funded
  - Austin Families Child Care Management Svcs -- privately contracted providers

EARLY INTERVENTION

- CEDEN Family Resource Center
- Child Inc/Head Start
  - EPSDT
- Neonatology Hospital Unit
- Pediatric Home Care
- Capitol Area Easter Seals Parent Program
- MHMR Infant Parent Program
- Regional Day School for the Deaf

FAMILY SUPPORT

- CEDEN Family Resource Center
- Any Baby Can
- Community Advocates for Teen Parents
- Teen Parent Council

EARLY CHILDHOOD PLANNING BODIES
Interagency Council on Early Childhood Intervention (ECI)
Child Welfare Board
Child Care Council
* ECI Advisory Committee
- Central Texas Infant Forum

RESOURCE & REFERRAL SERVICES

Austin Families, Inc.
Connections Resource Center
Austin Community College

School Districts
Pre-K Programs
Early Childhood Services
Pregnancy Educ & Parenting Programs

Mental Health Association & Svcs

Child & Family Services

Austin Child Guidance Center

Literacy and Job Placement Programs

* Still in Planning and Development Stages

TRAVIS COUNTY DEMOGRAPHIC PROFILE

TOTAL POPULATION	STATE	COMMUNITY
• total population	16,986,510	576,407
• African-American	11.9 %	10.9 %
• American Indian	< 1 %	< 1 %
• Asian	1.8 %	2.8 %
• Caucasian	75.2 %	73.3 %
• Hispanic - not included in total count	25 %	21 %
• Other	10.6 %	12.4 %
• below poverty level	24 %	18 %
• unemployed	7.1 %	6.0 %
• Medicaid recipients	97 %	74 %
• WIC recipients	35 %	30.5 %
• high school grads	unavailable	52.2 %
• Live births - all ages	18.6 %	18.2 %
• Live births maternal age <18 years	unavailable	unavailable
• Low birth weight	6.9 %	6.2 %
• Infant mortality	8.9/1000	7.3/1000

LOCAL SERVICE SYSTEM PROFILE	LIAISON PROGRAM	COMMUNITY SERVICE SYSTEM
• total 0-3 served	302	943
• of 0-3 served, % poverty level	56 %	77 %
• total direct service staff	10	43
• bilingual staff & sign language	6	13
• total ethnic minority staff	8	24
• total staff live in community	10	43

The information presented here represents data from 1990 and 1991. See Appendix B: Community Case Study Issues for discussion of accessibility of statistical data and its implications for service planning and delivery.

Figure 2

Chart I	Major Funding Source	Universal Access 0-3	Ease of Access	Cultural Inclusve	Center or Home Base	# Indiv Served 1990	Referral Follow up	Training Type	Training Hours	Staff Turnover	Parent Involvmnt	Eval.
Prenatal Hlth Svcs.	a,b,c	yes	a,b,c f,g,h	a,b,c	both	540	yes	a,b,c	d	unavail	a,b,c	a,b
Perinatal Svcs.	a,b,c	yes	c,d,g,h	a,b,c	both	540	yes	unavail	d	unavail	a,b,c	a,b
Teen Preg. Prog.	b,d	yes	a,b,f,g,h	a,b,c	both	unavail	yes	a,b,c	d	unavail	a,b,c	a,b
Childbirth Educ.	b	yes	a,b,f,h	a,b,c	both	unavail	yes	a,b,c	a	voluntr	a,b,c	b
WIC Program	e	no	unavail	a,b,c,d	center	15,616	yes	unavail	unavail	unavail	unavail	unavail
Head Start	e	yes	a,b,e,f,g	a,b,c,d	c,h	1183	yes	a,b	c	9%	a,b,c,d,e,f,g	f,h
Primary Hlth Care	a,b,c,d	yes	unavail	a,b,c,d	center	unavail	yes	unavail	unavail	unavail	unavail	unavail
Immunization	b,c,d	yes	a,b,f,g,h	a,b,c,d	center	unavail	no	unavail	unavail	unavail	unavail	unavail
Parenting Instruction	a,b,c	yes	a,b,c f,g,h	a,b,c,d	both	119	yes	a,b,c	d	unavail	a,b,c	b
High Risk Registry	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Inf/Tod.Dev. Screening	a,b,c	yes (ECI)	a,b,c e,f,g	a,b,c,d	both	5,888	yes	a,b,c	d	unavail	a	b
Tracking System	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Child Care	a,b	no	abcefg	a,b,c,d	both	unavail	yes	unavail	unavail	unavail	a,b,c	unavail
Early Intervention Infants	a,b,c	yes (ECI, CEDEN)	a,c,d f,g,h	a,b,c,d	both	707	yes	a,b	d	12.5%	a,b,c	a,b,d
Toddlers	a,b,c	yes	acdfgh	a,b,c,d	both	unavail	yes	a,b	d	12.5%	a,b,c	a,b,d

KEY

Major Funding Source

a private
b public: local
c public: county
d public: state
e federal
f client fees
g 3rd party
h other

Ease of Access

a central geographical location
b flexible hours of service
c accessible to public transportation
d transportation provided for the disabled
e transportation universally provided
f bilingual staff (including for hearing impaired)
g wheelchair accessible
h waiting lists monitored and updated
j other

Cultural Inclusiveness

a population served is culturally and/or economically reflective of the population in need of services
b public awareness campaigns target diverse groups
c staff reflect the diversity of the population serviced
d use culturally appropriate/sensitive assessment tools

Training Type

a content that focuses on assessing children, working with individuals or families
b content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c other (specify)

Training Hours

a 8-20 hours
b 20-40 hours
c 40-80 hours
d 80 + hours

Parent Involvement

a as member of child's staffing team
b in support groups
c in parenting classes
d on advisory committees
e as board member
f as staff
g other

Evaluation

a self administered
b parent agency administered
c county administered
d state administered
e federal
f all of the above
g other_____specify
h parents are a part of the evaluation team

unavail = unavailable n/a = not applicable

Figure 3

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Chart II (1991 figures)	Major Funding Source	Universal Access	Recruitmt Enrollmt Type	Services Offered	Ease of Access	# Indiv. Served 1991	Referral w/ Followup	Family Needs Assessmt	Indiv. Svcs.	Group Svcs.	Support Groups	Cultural Inclusive	Training Type	Training Hours
GED Classes	abcde	yes	a,b,c	unavail	acdefg	1,436	unavail	yes	yes	yes	unavail	a,b,c,d	n/a	n/a
Employment Counseling & Placement	c,d,e	yes	a,b,c	unavail	a,c,f,g	unavail	unavail	unavail	yes	yes	unavail	a,b,c	n/a	n/a
Housing Assistance	b,c,d,e	^	a,b	unavail	a,c,f	unavail	unavail	yes	unavail	unavail	unavail	a,b	n/a	n/a
Financial Assistance (Medicaid; AFDC; SSI)	d,e	means tested	a,b,c	unavail	a,c,f	13,803*	unavail	unavail	unavail	unavail	unavail	a,b,c,d	n/a	n/a
Mental Health Evaluation & Referral	c,d,e	yes	a,b	unavail	a,e,f	unavail	unavail	yes	unavail	unavail	unavail	unavail	a,b,c	c
Substance Abuse Treatment	d,e	^	a,b	unavail	unavail	unavail	unavail	unavail	yes	yes	unavail	unavail	n/a	n/a
Child Abuse Prevention & Detection Program	a,b,c	yes	a,b,d	unavail	a,e	unavail	unavail	yes	yes	yes	unavail	unavail	a,b,c	c

KEY

Major Funding Source

a	private	e	federal
b	public:local	f	client participant fees
c	public county	g	3rd party payment
d	public state	h	other

Recruitment/Enrollment Type

a	self referral
b	referrals from other programs
c	outreach from this program
d	other

Services Offered

a	Direct services
b	Screening/assessment
c	Referral for other services
d	Other

Ease of Access

a	Central geographical location
b	Flexible hours of service
c	Accessible to public transportation
d	Transportation provided for the disabled
e	Transportation universally provided
f	Bilingual staff (including for hearing impaired)
g	Wheelchair accessible
h	Waiting lists monitored and updated
i	Other

Cultural Inclusiveness

a	population served in culturally and or economically reflective of the population in need of services
b	public awareness campaigns target diverse groups
c	staff reflect the diversity of the population serviced
d	use culturally appropriate/sensitive assessment tools

Training Type

a	content that focuses on assessing children, working with individuals or families
b	content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c	other (specify)

Training Hours

a	8-20 hours
b	20-40 hours
c	40-80 hours
d	80+ hours

^ = income restricted * = figure is for AFDC

n/a = not applicable unavail = unavailable

Figure 4

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SNOHOMISH COUNTY, WASHINGTON

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SNOHOMISH COUNTY, WASHINGTON

DEMOGRAPHIC PROFILE

Snohomish County, Washington lies immediately north of Seattle. The county, covering slightly more than 2,000 square miles, is bordered on the west by Puget Sound and on the east by the crest of the Cascade mountains. Everett, the county seat, with a population of approximately 70,000, is located on the Sound and began as a lumber port. Including the suburbs of Seattle, small towns, rural areas, Native American reservations, and forests, Snohomish County is in many ways a microcosm of Washington State.

The population of Washington state is increasing, and Snohomish County is growing even faster than the state as a whole. Between 1980 and 1990, the population of the state increased by 17.8 percent, to 4.85 million, while the county's population increased by 37.9 percent, to 466,000. Most of the population increase has been among Caucasians, but the county's African-American, Asian American, and Native American populations have also increased. Many Asian Americans in the county were born outside the United States.

When the case study began, Snohomish County was thriving economically. It housed the largest Boeing Corporation plant and the Scott Paper Company. Two military bases, Naval Station Puget Sound and the Everett Base Port, are located in the county. Since 1990, however, significant downsizing in the military, the timber industry, and related manufacturing (including Boeing and Scott Paper) has hurt the economy of the county, as well as that of the state.

Snohomish County's infant mortality rate of 5.9 is lower than the state rate and has decreased since 1980. County rates of reported child abuse, however, are the highest in the state -- possibly as a result of some highly publicized cases several years ago. Eighty-two percent of high school students in the county graduate.

Several Snohomish County interviewees referred to a strongly "individualistic" mindset among county residents, not only among farmers and lumbermen but also among newly arrived families who are looking for work. The interviewees suggested that this philosophy accounts for ambivalence among at least some of the county's influential citizens toward the prospect of expansive health and social services. Recently voters disapproved a methadone clinic and additional low-income housing for the county.

HISTORICAL OVERVIEW OF THE SERVICE SYSTEM

State and county-level interviewees observe that the State of Washington has a tradition of using categorical funding streams to support services for very young children, housed in a range of agencies and staffed by professionals from diverse disciplines. By 1984, professionals in Snohomish County had begun to meet regularly in order to become better informed about the range of services available to the families with whom they worked, and to share staff development information. When the state applied to participate in Part H of P.L. 99-457, it selected Snohomish County as the

site of the first county-level Interagency Coordinating Council (ICC). The County ICC was established with representatives from the health district, Child Protective Services, and mental health, education, and developmental services. Interviewees noted that representatives to the County ICC were **middle**-level agency staff, who recognized the need to inform their agency directors and work to increase involvement of policy makers throughout the state in this new venture.

P.L. 99-457, the Amendments to the Education for the Handicapped Act, was passed in 1986. That same year, the murder of a child by his stepfather in Snohomish County created statewide alarm about child abuse and resulted in the establishment of a 25-member Children's Commission. Its mandate was "to identify, analyze, and prioritize the problems of children in the county." The Commission is supposed to serve as both "think tank" and advocate, looking at the array of existing services for children from birth to 21 and at unmet needs.

During the course of the case study, interviewees began to express a sense that Washington, which was an early leader in prevention and early intervention services for young children and their families, has fallen behind. Service providers describe larger caseloads, as the population has increased but resources have not. One case manager, who has a caseload of 250 individuals with developmental disabilities, says that she can no longer meet her clients face to face, but must coordinate services by telephone alone. New categorical services for targeted populations have been funded, but new services increase the burden on workers who must keep informed about new programs and attend more meetings. The sense of a service **system** is missing. As one interviewee put it, "Our system is a hodge-podge." Another said, "There is no system, except for the seriously developmentally disabled." A third respondent observed, "This only works because people bend the rules."

CURRENT SERVICE SYSTEM

Services currently available to infants, toddlers, and families in Snohomish County include health services, early intervention services, preschool transition programs, and family support services. (See Figures 1 through 4). The Snohomish County Interagency Coordinating Council, funded primarily by the state Part H program, is the primary coordinating body in the county, although several other planning and policymaking bodies are also active.

Of particular note in Snohomish County are the **Birth to Six Child Study Teams**, established in 1988 with support from Part H funds and reporting to the County Interagency Coordinating Council. Teams include representatives of various agencies (Child and Family Services, Health, Mental Health, the school district, Division for Developmental Disabilities) and are designed to address the needs of multi-problem families. Teams meet monthly to discuss cases in an effort to provide interagency cooperation, ongoing facilitation, and coordinated case management services. Specifically, the team helps to provide families with services they require and/or helps to better coordinate services the families are currently receiving. Intervention plans, based on the parents' concerns and family strengths, are reviewed every six months. The case is closed when the team and the family agree that services

are no longer needed. The service is free of charge, and children need not be delayed in order to qualify. Parents may self-refer to the team.

Since mental health services for young children are a rarity anywhere in the country, the longevity and robustness of **Olympic Mental Health (OMH)**, a private, non-profit organization and United Way agency that has been serving the county since 1972, are worth noting. Five OMH Family Centers, located in various parts of the county and funded from public and private sources, serve children who are emotionally and/or behaviorally disturbed; who have been sexually or physically abused; or who have developmental delays, and their families. Services include counseling, day treatment classrooms, parent education, the Family Resource Coordination Parent and Preschool Group, and the Child Advocacy Project, a special program for sexually-abused children that is funded by the Department of Social and Health Services and staffed, for services to children from birth to 6, by OMH, the Prosecutor's Office, and the Providence Hospital Sexual Assault Center. In addition, Olympic Mental Health has served as the lead agency for the ICC, coordinates the Birth-to-Six Child Study Teams, and has staff members on the Children's Commission.

Snohomish County's four **Family Resource Centers** illustrate flexible design in prevention-oriented, community-based programs. Each center provides a different mix of services, depending upon the needs of the community in which it is located. Services may include parent support groups, language classes, parenting skills training, Parents Anonymous, after-school programs, and play groups. Family Resource Centers are supported by United Way, a grant from the timber industry, the Washington Council for the Prevention of Child Abuse and Neglect, other local foundations, and individual contributions.

Head Start is a major provider of services to young children in Snohonish County. The system is discussed in detail in the next section.

COMMUNITY SELECTION CRITERIA AS REFLECTED IN SNOHOMISH COUNTY

Universal access to services

Universal access to all services remains an unrealized goal, largely because income eligibility requirements exclude the working poor from many programs. One key provider in the community observed, however, that "access to needed services is almost always available, although funding streams and eligibility requirements make it complicated to provide," and waits may be long for limited "free" slots.

In addition to income-related eligibility criteria, age criteria may impede access to services among families with young children. In Snohomish County, differing age cut-offs for eligibility for Head Start and Part H programs are impeding the federally mandated efforts to link Head Start and birth-to-three service programs.

Illustrating one dimension of the need for adequate data in order to plan and evaluate community-level services integration is the absence of good information about the extent to which Snohomish County's Native American families are able to access

the services they need for their infants and toddlers. Several community service providers observed that Native American families who use services are not identified as such. Staff of public agencies in the county note that the Indian Health Service and tribal councils have developed their own services and that some tribes with substantial resources, like the Tulalip, prefer to serve Native Americans who live on the reservations themselves. Smaller and poorer tribes are unlikely to be able to provide their own services; unfortunately, these tribes, living in the rural northeastern part of the county, are geographically isolated from most county services.

Inclusive, non-categorical settings for services

Snohomish County is currently struggling with the issue of inclusive, non-categorical settings for infant/toddler services. Like other communities which were leaders in developing high-quality center-based programs for preschool children with special needs, Snohomish finds it a challenge to change this system. Parents want mainstreaming, but professionals worry that in inclusive settings lack staff with sufficient clinical expertise to serve children with special needs well.

Interviewees noted that, in general, community-based programs seem to be more successful than school districts in providing inclusive services. However, new Head Start disability regulations and mandated inclusive environments for preschoolers with disabilities served by school districts may have created what one interviewee called "the administrable moment" for cross-system collaboration around inclusion.

Professional development opportunities

Retaining qualified staff in infant/family programs is a constant challenge in Snohomish County; one interviewee remarked, "You have to have a sense of mission to stay with this." Interviewees observed repeatedly that service providers, regardless of discipline, who work with infants and toddlers are paid less than those working with school-age children. The problem may be largely one of auspice -- practitioners employed by the school system earn higher salaries than those working in the private, non-profit agencies that tend to serve younger children and their families.

Training opportunities within Snohomish County include Volunteers of America (VOA)-sponsored training for child care providers on working with children with special health care needs and/or disabilities. There is also a support group for "family workers" that offers informal consultation and programs with outside speakers.

Commitment to family support and leadership

At the service delivery level in Snohomish County, both parents and professionals observed change in recent years. One interviewee expressed what seemed to be a consensus: "We began with more of a **child** focus. Now we have more of a **family** focus." As participants in service programs, parents seem to be recognized within the special needs professional community as experts on their own families' strengths and needs. The "rolling assessment" process, in which a child's functional status is assessed over time, illustrates a commitment to ongoing consultation between professionals and parents.

The Native American community, however, remains largely outside this system. One community provider observed, "Although the ICC has had a cultural sensitivity training session, we still don't have any real understanding of the Native American communities. They are supposed to use center-based early intervention programs 40 miles away from where they live. But they have no cars." Another interviewee noted, "We have invited people to participate in what **we're** doing instead of going out and finding what **they** need!"

Change has also occurred at the level of policy development. Parents were not involved in the county Interagency Coordinating Council (ICC) at its inception but now serve on the ICC and the Children's Commission. A parent is co-chair of the ICC. Parents were encouraged by the County ICC to apply for family resource coordinator (case manager) positions, but educational requirements made a number of parents ineligible.

The lack of diversity among parents who are actively involved in planning and leadership roles continues to be a concern among members of the Snohomish ICC. One interviewee commented that "the ICC is almost entirely made up of white female professionals." No Native American, Asian, or Latino parents are members. An outcome of a retreat to discuss this issue was a budget, supported by the state, which pays parent members of the ICC $25 for each meeting they attend.

CRITICAL ISSUES REFLECTED IN SNOHOMISH COUNTY

Linkages across a range of levels of care and service system needs

In the words of one interviewee, "(Snohomish County) is the most collaborative community I've ever worked with. The ethic is, 'Let's find a way to work together.' Territoriality is the exception, not the norm. It happens, but when it does, people are surprised." While informal interagency linkages among individuals who have worked together and trust each other are strong, turnover in personnel could erode these commitments in the absence of formal agreements.

Currently, the Interagency Coordinating Council and Head Start serve as the center of separate but overlapping linkage systems.

The Interagency Coordinating Council's strongest links are to the Department of Social and Health Services (especially Child Protection Services), the private health care provider system, and mental health services. As discussed above, Olympic Mental Health has served as the lead agency for the ICC and coordinates the Birth-to-Six Child Study Teams.

Formal interagency agreements among local agencies serving children with disabilities and their families are now legislatively mandated by the state. The local-level interagency agreements are designed to foster agencies' commitment to: increase community awareness of the mission of the ICC; increase involvement of the county's diverse population in the work of the ICC; and allocate staff time and resources to participation in the work of the ICC.

A common referral form for all 16 services included in the Part H service system is also designed to strengthen linkages among county services.

The county Head Start program has developed its own system of linkages with service programs in the county. In fact, these linkages are often more formalized than those among other providers in the county. (The Head Start Director observes, however, that differing eligibility criteria, administrative requirements, and financial reporting procedures impede linkages between Head Start and categorically-funded early intervention programs.) The following examples of Head Start's linkages suggest the scope and diversity of these arrangements:

- Head Start's successful linkage with **Olympic Mental Health** programs can be traced in part to co-location of these programs, either in the same building or in the same community. The resulting informal linkages among front-line workers support the formal arrangements negotiated by program administrators. Head Start and Olympic Mental Health are working together to develop more inclusive early childhood education services, and Olympic Mental Health (by contract) provides mental health consultation to Head Start itself.

- Head Start is described by its Director as having "worked long and hard with **Child Protective Services**. Head Start sees CPS as a support to families and as a preventive agency, rather than in the "enforcer" role usually attributed to them." Head Start and CPS have a formal collaborative agreement covering procedures for reporting suspected abuse, and it is felt that this agreement strengthens Head Start's work with families and provides a better understanding between the two agencies of each other's services.

- Head Start has experienced mixed success in working with **medical and dental providers**. Physicians in the community are described as "open and easy to work with," but dentists are less accessible to the Head Start population, possibly because of the state reimbursement system.

- Head Start works actively on nutrition issues with **WIC**, the **County Extension Program's Feeding and Nutrition Education Program (EFNEP)**, and **Public Health Nurses**. Head Start's family service workers, each with a caseload of 34 families, contact WIC regularly around referrals. EFNEP workers provide training for and with Head Start and will also make home visits to families to work on nutrition issues.

- Head Start is a part of the Family Resource Center established by the **Volunteers of America**.

State support and encouragement

The austerity measures resulting from statewide economic difficulties described earlier in this section limited what had been an exemplary system of services, particularly for children with special needs. Community stakeholders pointed to

several policies that, while understandable from a fiscal perspective, nevertheless compromise the county's ability to plan and build a solid **system** of services. These are:

- more stringent eligibility requirements for services;
- requirements that programs return unexpended funds to state general revenues; and
- zero-based budgeting, which leaves community advocates with a sense that "the one-shot stuff passed in special session (of the legislature) might be taken away next year."

These constraints notwithstanding, Washington state agencies have tried to improve early childhood services through interagency collaboration at the state-level. One example is the **Regional Support Network (RSN)** -- a Department of Social and Human Services/Department of Mental Health statewide program that is connected to EPSDT, to fund mental health services for children from 18 months of age. State agencies also collaborate with federally-funded initiatives, for example statewide parent/child health surveys and training through the Maternal and Child Health National Resources Center on Cultural Diversity. The Medical Home Project is a collaborative effort to identify and implement strategies to improve access to primary health care services for children with special needs, involving the American Academy of Pediatrics and the State Department of Health which is supported by Title V funding. Washington's Early Childhood Education Assistance Program (ECEAP) serves preschool children who meet the income eligibility guidelines for Head Start but who cannot be served by already at-capacity Head Start Programs.

The structure of the **State Interagency Coordinating Council** funded by Part H, which includes representatives from each county Part H Interagency Coordinating Council as well as private-sector service providers, is designed to facilitate vertical coordination between county-level and state-level planning for young children with special needs and their families. County-level ICCs make their own funding commitments (for example, Snohomish's decision, described above, to pay parent members for attending ICC meetings), but, in addition, the State ICC tries to "braid" or combine funding streams to respond to the unique needs of each county.

In 1992, legislation was passed authorizing **The Birth to Six State Planning Project** (a planning body that had existed since 1984) to be funded by Part H. The Birth to Three State Planning Project includes five state agencies (Health, Education, Community Development, Social Services and Services for the Blind) which have interagency agreements to fund and administer a statewide system of care for the birth-to-three population.

As a component of the State ICC, the Birth to Six State Planning Project supports community-level services by funding:

- *County Interagency Coordinating Councils* - Funding is available to each county to support Interagency Coordinating Councils which are working to enhance coordinated, comprehensive services for local families with children under three years of age with disabilities. Some of their activities are to:

  - share information from the State Interagency Coordinating Council;
  - discuss Child Find and Public Awareness activities within the county;
  - coordinate with Interim Family Resources Coordinators; and
  - discuss outreach to minority, low-income, and rural representation.

- *Interim Family Resources Coordination* - Each county receives funding to provide Interim Family Resources Coordinators (IFRCs) to assist families in identifying services currently available. Implementation varies from county to county. The IFRC's role is to work with families, agencies, and providers to enhance the service system in their counties. IFRCs are available to:

  - assist families from the point of referral, and at the family's request, through screening, evaluation and assessment; the development of an Individualized Family Service Plan, and transition to Case Management (Service Coordination);
  - coordinate with County Interagency Coordinating Councils;
  - assist with building bridges between families and agencies; and
  - collect data about services and gaps in services to share with state and federal governments.

During the case study period, several early childhood policy and planning initiatives began in Washington. The case study team found that state-level and community-level interviewees had different perspectives on the degree to which new state-level efforts designed to support integrated early childhood services would be likely to have a significant positive impact at the county level.

For the population of children and families as a whole, the **Family Policy Council** was described by state-level interviewees as "an enhancer of linkage at the county level." The Council was established by legislation in 1992, as part of the Family Policy Initiative that directs five state agencies (Health, Education, Social Services, Community Development and Employment) to restructure their services in order to "improve responsiveness to requests for services for at-risk children and families." The legislation calls for local policy councils, similar in make-up to the state-level councils, that will plan and coordinate services. The state-level Council is responsible for soliciting proposals for community-based collaborative efforts and making recommendations to the Governor for funding these efforts through the budgets of participating state agencies.

At the county level, however, interviewees expressed concerns about the new local councils. One informant was worried that early intervention services might be neglected; another pointed to insufficient numbers of some categories of health care providers in the county, which reorganization mandated by the Family Policy Initiative would be unlikely to address and added, "(The state) want(s) everybody to learn a new dance but they want us to do it to waltz music."

COMMUNITY SYSTEM FOR FAMILIES WITH YOUNG CHILDREN
SNOHOMISH COUNTY, WASHINGTON

COMPREHENSIVE POLICY AND PLANNING BOARDS
- The Family Policy Council (The Family Academy)
- Children's Commission
- Council for Integrated Children's Programs

Parent to Parent Network

EARLY CHILDHOOD SERVICES SYSTEM

FAMILY SUPPORT

- First Steps
- Family Independence Program
- Family Pride
- Olympic Mental Health Family Centers
  - Child Advocacy Project (CAP)
- Deaconess Children's Services
  - IMPACT Parent Infant Program
- Family Support Centers
- Dept of Social & Health Services (DSHS)
  - Div of Child & Family Services (DCFS)
    - -- Child Protective Svcs
    - -- Child Welfare Svcs
  - Div of Developmental Disabilities (DDD)
- Family Resources Coordination Project (FRCP)
- Little Red School House
- Volunteers of America (VOA)
  - Child Care Resource & Referral
  - Baby Your Baby Program

HEALTH-ORIENTED

- Snohomish County Health District
  - Well Child Clinics
    - -- EPSDT
  - First Steps
  - The Maternity Care Access Plan
  - Family Pride
- OMH Family Centers
- Deaconess Children's Services
  - IMPACT PIP
- Providence Hospital Children's Ctr
- Community Health Center
- DSHS
  - Healthy Kids (EPSDT)
  - DDD
- Everett Clinic
- WIC
- Indian Health Services

EARLY INTERVENTION/PRESCHOOL

- Continuum of Care Project
  - Family Resource Coordination Parent & Preschool Group
- Head Start
- Early Childhood Education & Assistance Program (ECEAP)
- Joint Agency Model Preschool Classroom (JAM)
- Deaconess Children's Services
  - IMPACT PIP
- Providence Hospital Children's Center
- DSHS
  - DCFS
  - DDD
    - * FRCP
    - * Child Profile Follow-up (HPIT)
    - * Automated Info Mgmt Systems (AIMS)
- Little Red House
- Sherwood Excel Learning Center
- Office of Superintendent of Public Instruction
  - Early Identification (Child Find)

EARLY CHILDHOOD PLANNING BODIES
- Birth to Six State Planning Project
- Snohomish County Interagency Coordinating Council
- Birth to Six Child Study Teams

State/Local Educ Agencies School Districts Univ of WA

155

159

160

SNOHOMISH COUNTY DEMOGRAPHIC PROFILE

TOTAL POPULATION	STATE	COMMUNITY
• total population	4,866,692	465,642
• African-American	3 %	1 %
• American Indian	2 %	1 %
• Asian	3 %	3 %
• Caucasian	87 %	93 %
• Latino	3 %	2 %
• Other	2 %	unavailable
• below poverty level	24 %	16.7 %
• unemployed	2.5 %	5.2 % (1991)
• Medicaid recipients	8.1 %	3.0 %
• WIC recipients	1.3 %	< 1 %
• high school grads	unavailable	82.1 %
• Live births - all ages	16.3 %	17.8 %
• Live births maternal age <18 years	< 1 %	< 1 %
• Low birth weight	5.3 %	4.7 %
• Infant mortality	unavailable	5.9/1000

LOCAL SERVICE SYSTEM PROFILE	LIAISON PROGRAM	COMMUNITY SERVICE SYSTEM
• total 0-3 served	unavailable	10,525 (duplicated count)
• of 0-3 served, % poverty level	unavailable	56 %
• total direct service staff	unavailable	120
• bilingual staff & sign language	unavailable	15
• total ethnic minority staff	unavailable	5
• total staff live in community	unavailable	60

The information presented here represents data collected from 1990. See Appendix B: Community Case Study Issues for discussion of accessibility of statistical data and its implications for service planning and delivery.

Figure 2

Chart 1	Major Funding Source	Universal Access 0-3	Ease of Access	Cultural Inclusve	Center or Home Base	# Indiv Served 1990	Referal Follow up	Training Type	Training Hours	Staff Turnover	Parent Involvmnt	Eval.
Prenatal Hlth Svcs.	a,d	yes	a,c,d,g	b	both	4702	yes	a	d	0	a,b	a,d
Perinatal Svcs.	a,d	yes	a,c,d,g	b	both	5158	yes	a	d	0	a,b	a,d
Teen Preg. Prog.	a,b,c,d	no	a,c,d,g	unavail	center	unavail	yes	unavail	unavail	unavail	a,b	unavail
Childbirth Educ.	a,b,c	no	a,b,c,g,j	unavail	center	unavail	unavail	unavail	unavail	unavail	unavail	unavail
WIC Program	e	no	a,c,d,g	unavail	center	1862	yes	a	d	unavail	unavail	unavail
Head Start	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
Primary Hlth Care	a,d	no	unavail	unavail	center	unavail	information unavailable					
Immunization	a,d	yes	a,c,d,g	unavail	center	26899	yes	unavail	unavail	0	unavail	unavail
Parenting Instruction	a,b,c,d	no	a,b,c,d,g,h	unavail	both	217	yes	a,b	d	unavail	a,b,c,d,f	a,d,h
High Risk Registry	see	tracking	system	*	*	*	*	*	*	*	*	*
Inf/Tod.Dev. Screening	a,b,c,d	no	a,b,c,d,g	d	center & home	unavail	yes	a	d	unavail	a,b,c,d,e,f	a,d,h
Tracking System	d	no	hospital based	a,b	hospital	773	yes	a	d	0	a	a,d
Child Care	a,d	no	varies	b	both	approx 9,000	yes	a	a	unavail	unavail	d
Early Intervention Infants	a,b,c,d	no	a,b,c,d,e,f,g,h	d	both	447	yes	a,b,c	d	2%	a,b,c,d,e,f	a,c,d,h
Toddlers	a,b,c,d	no	a,b,c,d,e,f,g	d	both	447	yes	a,b,c	d	2%	a,b,c,d,e,f	a,c,d,h

KEY

Funding Source

a private
b public: local
c public: county
d public: state
e federal
f client fees
g 3rd party
h other

Ease of Access

a central geographical location
b flexible hours of service
c accessible to public transportation
d transportation provided for the disabled
e transportation universally provided
f bilingual staff (including for hearing impaired)
g wheelchair accessible
h waiting lists monitored and updated
j other

Cultural Inclusiveness

a population served is culturally and/or economically reflective of the population in need of services
b public awareness campaigns target diverse groups
c staff reflect the diversity of the population serviced
d use culturally appropriate/sensitive assessment tools

Training Type

a content that focuses on assessing children, working with individuals or families
b content that focuses on self awareness (e.g. stress management, cultural competency, etc.)
c other (specify)

Training Hours

a 8-20 hours
b 20-40 hours
c 40-80 hours
d 80 + hours

Parent Involvement

a as member of child's staffing team
b in support groups
c in parenting classes
d on advisory committees
e as board member
f as staff
g other

Evaluation

a self administered
b parent agency administered
c county administered
d state administered
e federal
f all of the above
g other_____specify
h parents are a part of the evaluation team

unavail = unavailable * = see tracking system

Figure 3

Chart II	Major Funding Source	Universal Access	Recruitmt Enrollmt Type	Services Offerred	Ease of Access	# Indiv. Served 1990	Referral w/ Followup	Family Needs Assesamt	Indiv. Svcs.	Group Svcs.	Support Groups	Cultural Inclusive	Training Type	Training Hours
GED Classes	b,c,d	yes	a,b	a,b	a,b,c,d,g,h	unavail	no	no	no	yes	no	unavail	unavail	unavail
Employment Counseling & Placement	a,b,c,d	no	a,b,c	a,b,c	a,b,c,d,g,h	unavail	yes	no	yes	yes	yes	unavail	unavail	unavail
Housing Assistance	a,b,c,d	no	a,b,c	a,b	a,c,d,g,h	unavail	yes	no	yes	no	no	unavail	unavail	unavail
Financial Assistance (Medicaid; AFDC; SSI)	d	no	a,b	a,b,c	a,c,d,f,g,h	unavail	no	no	yes	no	no	unavail	unavail	unavail
Mental Health Evaluation & Referral	a,b,c,d	no	a,b,c	a,b,c	a,b,c,d,g,h	unavail	yes	yes	yes	yes	yes	consult	a,b,c, counseling	d
Substance Abuse Treatment	a,b,c,d	no	a,b,c	a,b,c	a,b,c,d,g,h	unavail	yes	no	yes	yes	yes	unavail	a,b,c counseling	d
Child Abuse Prevention & Detection Program	d	yes	a,b,c	a,b,c,d	a,c,d,g	unavail	yes	yes	yes	yes	yes	b consult	a,b,c counseling	d

KEY

Major Funding Source

a	private	e	federal		
b	public:local	f	client participant fees		
c	public county	g	3rd party payment		
d	public state	h	other		

Recruitment/Enrollment Type

a	self referral
b	referrals from other programs
c	outreach from this program
d	other

Services Offered

a	Direct services
b	Screening/assesament
c	Referal for other services
d	Other

Ease of Access

a	Central geographical location	f	Bilingual staff (including for hearing impaired)
b	Flexible hours of service	g	Wheelchair accessible
c	Accessible to public transportation	h	Waiting lists monitored and updated
d	Transportation provided for the disabled	i	Other
e	Transportation universally provided		

Cultural Inclusiveness

a	population served in culturally and or economically reflective of the population in need of services
b	public awareness campaigns target diverse groups
c	staff reflect the diversity of the population serviced
d	use culturally appropriate/sensitive assessment tools

Training Type

a	content that focuses on assessing children, working with individuals or families		
b	content that focuses on self awareness (e.g. stress management, cultural competency, etc.)		
c	other (specify)		

Training Hours

a	8-20 hours
b	20-40 hours
c	40-80 hours
d	80+ hours

unavail = unavailable

Figure 4

BEST COPY AVAILABLE

PROJECT ADVISORY COMMITTEE

Kathryn Barnard, Ph.D., R.N.
Professor
University of Washington
Seattle, Washington

Julianne Beckett
Program Associate, Child Health Specialty Clinics
University of Iowa
Iowa City, Iowa

Sara B. Bonam, M.S., R.D.
Director, Nutrition Training & Technical Assistance
Division of Nutrition
Albany, New York

Frank Farrow, Ph.D.
Director, Children's Services Policy
Center for the Study of Social Policy
Washington, D.C.

Linda Gilkerson, Ph.D.
Professor
Erikson Institute
Chicago, Illinois

William Hollinshead, M.D.
Medical Director
Division of Family Health
Rhode Island Department of Health
Providence, Rhode Island

Phyllis Magrab, Ph.D.
Director, Child Development Center
Georgetown University
Washington, D.C.

Samuel Meisels, Ed.D.
Professor & Research Scientist
School of Education
University of Michigan
Ann Arbor, Michigan

Dolores G. Norton, Ph.D.
Professor, School of Social Service Administration
University of Chicago
Chicago, Illinois

Diana Robinson
Family Support Supervisor
Garfield Head Start
Chicago, Illinois

Gloria Rodriguez, Ph.D.
Executive Director
AVANCE
San Antonio, Texas

Ruth Rucker
Executive Director
Edward C. Mazique Parent Child Center
Washington, D.C.

Lisbeth Schorr
Lecturer in Social Medicine
Harvard University Medical School
Boston, Massachusetts

Jack Shonkoff, M.D.
Dean, The Heller School
Brandeis University
Waltham, Massachusetts

Pascal Trohanis, Ph.D.
Principal Investigator, NEC*TAS
Frank Porter Graham Child
Development Center
Chapel Hill, North Carolina

G. Gordon Williamson, Ph.D., OTR
Director of Coping Project
Pediatric Rehabilitation Department
John F. Kennedy Medical Center
Edison, New Jersey

APPENDIX A: NATIONAL PARENT POLICY ADVISORY GROUP

PARENT INVOLVEMENT IN THE PLANNING AND IMPLEMENTATION OF COMMUNITY SERVICE SYSTEMS

Kim J. Amos, M.S.W.

Within communities, at the state-level, and nationally, parents are playing larger roles in the process of planning, developing, and implementing community-based systems of care. As consumers of existing services, parents and other family members offer direct testimony about issues including barriers to access to services, reasons underlying utilization of services, gaps and duplications in a service system, and the effectiveness of coordination efforts. As architects of family-centered models of care, parents contribute their specialized expertise and knowledge of their own children's circumstances and also their broader experience. Parent involvement in the system-building process includes participation in community focus groups and town meetings, service on advisory panels, and provision of testimony to legislative and other policymaking bodies. Increasing parent involvement is accompanied by growing demands from parents for acknowledgment of and support for the contributions they are making.

During the five years of its case study on services integration in six communities, the Promoting Success in Zero To Three Services Project examined parents' roles in planning and developing the system of services in those six communities. Individual interviews, focus groups, and a national policy advisory group of parent representatives from all six communities provided insights about the different levels and varying stages of development at which parent involvement was occurring.

Parents from all communities told us that families respond positively to a range of outreach strategies designed to increase their involvement in community-based services. While concrete supports -- such as child care, stipends, and accommodation to families' schedules -- are important, community commitment to family support and leadership is equally crucial. During the five years of the case study, most of the six participating communities were able to increase parent involvement even as they struggled with funding issues (and in at least one community, parent advocacy played a considerable role in protecting service budgets). At the same time, parent and professional interviewees in all six communities recognize and continue to address the need for participation in systems planning by families who have been traditionally under-represented in family advocacy and leadership roles, especially families with children who may be at risk of poor developmental outcomes.

Information from individual interviews and focus groups

At the beginning of the case study, the project liaison in each of the six participating communities was asked to identify parents willing to participate in individual interviews or focus groups during the study team's site visits. Focus group

participants received a $25 stipend, and child care was provided. In an effort to accommodate family schedules, most individual interviews were held in parents' homes. Through individual interviews and focus groups, we learned that parents were serving on parent advisory committees; working as paid staff; running parent support groups and mentoring programs; organizing fundraising campaigns; and leading local and state interagency coordinating committees.

The most active parents tended to be those with children with special needs. In many instances, the parents most involved in some kind of advisory and/or planning capacity tended to be those whose children were "graduates" of infant/toddler early intervention programs. The parents who had formal roles in program planning or policy development were few in number. Parents who were interviewed complained about the lack of opportunities for new parents to serve as advisors and planners of program and policy development; they reported that the same parent representatives were continually being "recycled" through the system.

When asked to identify barriers which they felt contributed to the lack of parent involvement in planning and developing a community's service system, parents cited the following:

- lack of outreach services to families, especially to low-income and minority families;
- lack of parent education on parental rights and resources (eligibility and entitlements);
- lack of organized training for parents wanting to serve on advisory boards and committees;
- lack of financial support for parent involvement activities (stipends for time served, child care, transportation, etc.);
- lack of new parent "recruits" reflecting the diversity of families; and, most often mentioned,
- a lack of recognition by professionals, in the school system especially, that families can be contributors to services as well as recipients of services, because families know best what they need.

The National Parent Policy Advisory Group

The National Parent Policy Advisory Group was established in 1991, two years into the case study. The federal Maternal and Child Health Bureau's Division of Children with Special Needs saw this parent advisory group as an important vehicle for putting into practice the Bureau's philosophy that involving parents as central actors in the development of family-centered, community-based, coordinated, culturally competent systems of care can create a powerful force for change in existing systems. One goal of the group, therefore, was to advise policy makers, within the Bureau and

in other federal agencies and national organizations, on the design and development of family-centered systems of care. A second, simultaneous goal of the National Parent Policy Advisory Group was the development among its members of a knowledge base and advocacy skills that would enhance their efforts at systems change at the community level.

The group was comprised of thirteen parents who had experiences with a wide range of community services, including primary health care services and services for children with special needs. In general, these parents tended to reflect the socio-economic, ethnic and cultural characteristics of the communities they represented. Some were "veteran" systems-change advocates, while others were "new recruits." Mothers, fathers, couples, single parents, grandparents, and foster parents met in Washington, D.C. three times over three years to learn and share information, and to provide insight to the case study team, the Maternal and Child Health Bureau, and others on how families negotiate an often fragmented system of services that is often unresponsive to their needs.

The group met with public policy makers and representatives of national organizations (including parent networks) who were committed to the issues of young children and their families. Parents met with representatives of the Maternal and Child Health Bureau's Divisions of Children with Special Health Needs, Maternal, Infant, Child and Adolescent Health, and Healthy Start; the Surgeon General's Office; and the Department of Health and Human Services' Office of Assistant Secretary for Planning and Evaluation. They also met with representatives of the national parent networks Family Voices, the National Center for Family-Centered Care, and the Federation for Children with Special Needs.

During these meetings, parents shared their positive experiences with services and service providers, as well as their difficulties with current policies and programs that continue to undermine the development of more cohesive family support systems. These included rigid or conflicting eligibility and funding requirements and uncoordinated services and support systems. Policy makers provided background and up-to-the-minute information on policy issues of concern to parent participants. Policymakers urged parents to expect accountability from all service providers, government agencies, and private industry for their standards of service to families. Policymakers challenged parents to use the knowledge and skills that they had developed in the National Parent Policy Advisory Group to mobilize other parents in their communities to advocate for the needs of their own children and families.

The parents responded to this challenge by developing strategic work plans. These work plans consisted of long and short-term goals for increasing parent involvement in community service, networking and public policy, at the community level. For example, upon returning to their communities, some parent group members established parent support groups and fathers' groups; they conducted community health fairs and taught parent education classes; they became active members on advisory committees and interagency review councils. Others spoke at meetings of parents and health professionals on issues related to parent involvement and provided assistance in writing grants for family support centers. One of the fathers in the parent

group became a statewide trainer for families applying for disability benefits for their children through SSI. These strategic work plans provided the parents with direction and purpose, and assisted them in remaining committed to the success of the National Parent Policy Advisory Group.

Sustaining commitment to the National Parent Policy Advisory Group

Sustaining parents' commitment to the National Parent Policy Advisory Group was not an easy task. Essential to the effort was assignment of a staff member of the case study team to the role of ongoing "convener" of the group. The convener had to first develop a level of trust with the group by listening to parents and responding to their concerns. When the federal Maternal and Child Health Bureau first requested that a parents' group be established, expectations were that ongoing support would be provided to the group over the life of the case study project. Over the three-year life of the group, three types of support were necessary to enable parents to remain invested in the group. These were:

1. Financial support -- Parent participants received a $300 stipend in addition to travel, meals, and lodging for their two-day meetings with public policymakers in Washington, D.C.

2. Administrative support -- Between annual meetings, the convener provided technical assistance by mail and telephone on effective strategies for systems-change advocacy. The group developed its own newsletter, *Family Focus*, which was duplicated and mailed by project staff.

3. Emotional support -- This was the type of support needed most by parents in the group; without it, parents' commitment to the National Parent Policy Advisory Group would have been next to impossible to sustain. Participation in this group helped parents to generate new choices for themselves and to develop and reshape positive images of themselves while having to undergo other transitions in their lives. During the four years that the group was in existence, group members and their families experienced separation, divorce, births, unemployment, illnesses, deaths, and other challenges that threatened long-term participation in the group. However, the trusting relationship that had been developed between the convener and the group members played a major role in sustaining commitment to the parents group. Phone calls for relaying information to the parents often turned into counseling sessions for the parents. Listening to the parents and advising them on the challenges they were facing in their everyday lives provided the convener with the opportunity to reciprocate the commitment that was asked of the parents.

Fortunately, there was an extremely low turnover rate among parents participating in the group. In an effort to maintain a real sense of connectedness to the parents group and to the case study project, the same parents were invited back annually. Only two new parents were introduced into the group over the three-year period.

Outcomes of the National Parent Policy Advisory Group

Representatives from national parent networks who met with the Parent Policy Advisory Group praised members for sharing their experiences as advisors to policy makers, observing that they were not only speaking for themselves, but for thousands of other families whose stories would remain untold. Group members were encouraged to use their advocacy skills to serve as role models and mentors for other families.

The positive response of the federal Maternal and Child Health Bureau is suggested by its invitation to the National Parent Policy Advisory Group to give a presentation on parent involvement at a conference of the Bureau's Community Integrated Service Systems (CISS) grantees. This activity helped to expand the family-centered care philosophy in a collaborative way across the Bureau. Federal policy makers also reported that having engaged in intensive dialogue with the parents' group over time has heightened their awareness of the impact their policies have had on young children and their families.

When asked to evaluate their own experience of participation in the National Parent Policy Advisory Group, parents responded in terms of:

- **personal growth**, especially as a leader (" I gained confidence in myself"; "I realized that I can truly make a difference"; "I feel motivated and inspired to be a changing voice in my community.")

- **strengthened connection to others engaged in a common endeavor** ("I felt a common bond and part of a 'blended family'"; "I feel informed and validated"; "I recognize the critical necessity of parents speaking out to community and national leaders"; "I realized the importance of including moms and dads in the process") and

- **increased knowledge and skills for advocacy and leadership** ("I became knowledgeable about policymaking"; "I am more aware of the needs and resources in my community"; "I learned how to be a resource to families and how to advocate for other families.")

The communities in which parent group members live also benefitted from the National Parent Policy Advisory Group experience. For example, liaison contacts in each community have become more aware of the need for input from a diverse group of families and continue to increase their outreach efforts to these families and others like them. Also, the pool of parent advocates at the community level will be enriched

by the participation of parents whose concerns and experiences relate to the broad range of comprehensive services.

Recommendations for increasing parent involvement

Recommendations are grouped into three categories: principles and attitudes, parent roles, and practical supports.

Principles and attitudes

1. Recognize and acknowledge the value of parent involvement. From the experience, families can learn to be resources to themselves and to their community.

2. Be clear about what you want from parents. Recognize parents as partners and experts in their own right. Avoid jargon and rhetoric.

3. Recruit parents with a range of viewpoints: identify "veteran" parents and "new recruits" of diverse socio-economic, ethnic, geographic and cultural backgrounds. Use parent involvement activities as a means of providing outreach to families who have been traditionally underserved or unserved, especially low-income, minorities, etc.

Parent roles

4. Provide meaningful opportunities for parent involvement: parents as planners, evaluators; on councils, boards, committees; as paid staff including trainers, counselors, mentors; presenters at workshops, conferences; and internships with professionals.

5. Provide orientations and training to enable families to effectively participate as systems-change advocates (planners, decision-makers, evaluators, trainers, volunteers, educators). Informed families make informed decisions. They need to know what to expect and what will be expected of them.

6. Encourage "rotating" parent positions. Often the same parents are "recycled" to serve on boards and committees. They become "tokens" rather than "legitimate spokespersons." Families and systems alike benefit when fresh voices and fresh faces enter the system.

7. Provide a forum for families where they can meet with local, state and federal agencies to discuss the potential roles of families as planners, educators, volunteers, etc. in these agencies.

Practical supports

8. Compensate families financially both for their time and for the costs of child care, transportation, parking, etc. A specific budget and efficient system for advancing funds to and reimbursing families is a must.

9. Provide the non-financial supports necessary to maintain parent involvement: be respectful of family schedules, lifestyles, culture and home language; maintain frequent contact by phone, mail, fax, etc.; offer 1-800 numbers and/or collect calling; be flexible, be available and be a good listener to families.

10. Allow sufficient time to build relationships among group members in order to sustain group cohesion. Create a separate group newsletter or a special section for the group within another newsletter.

Conclusion

Parents are most receptive to being involved as system-change advocates when they can see a sustained commitment from professionals to their involvement. The National Parent Policy Advisory Group exemplifies what can result from a sustained commitment to parent involvement, both nationally and at a community level. Through this experience, parents developed skills that supported their own efforts at system-building in their communities. Both parents and policy makers learned from each other, and, perhaps most importantly, they learned that collaboration is critical to the system-building process.

APPENDIX B: METHODOLOGY

CASE STUDY DESIGN, METHODOLOGY AND ISSUES

The Promoting Success Project applied traditional case study methodology to the study of six communities in various stages of service system development, following them as their service systems continued to evolve. This section of the project report describes the methodology used and discusses methodological issues that emerged from the case study experience.

DESIGN AND METHODOLOGY

The Promoting Success case study team received assistance from an advisory panel of practitioners, researchers, and parents who are recognized nationally as leaders and advocates in promoting quality early childhood services. The panel members are listed in the *Introduction* of this report. The panel was convened four times during the course of the case study, two of those times to meet with project liaisons from the six communities. The panel members assisted in the selection of the participating communities, and reviewed the methodology, data collection instruments, all drafts of the case study's *Preliminary Report* (February, 1993), and the final report.

The definitions, methodology, and techniques that are applied in the Promoting Success case study are consistent with those in current use for similar studies. The primary references for our process were the General Accounting Office Transfer Paper: *Case Study Evaluations* (1987), and *Case Study Design and Research Methods* by Robert Yin (1991). The Project staff also reviewed the increasing body of literature on community case studies and the organization of preventive and early intervention services, with special attention to publications by Robert Chamberlain, William Morrill, Lisbeth Schorr and the Institute for Educational Leadership. All of the sources are listed in the bibliography. This literature provides a variety of definitions for case studies. All sources agree that the case study is a methodologically sound way of conducting social science research as long as the study adheres to criteria for evaluating traditional research designs. These criteria concern:

- Study design based on problem definition, premise or hypothesis and choice of units of analysis;
- Data collection;
- Data review and analysis; and
- Report development and dissemination.

The case study allows an investigation "to retain the holistic and meaningful characteristics of real-life events -- such as individual life cycles, organizational and managerial processes, neighborhood change,...".(Yin, 1991) The extent to which our case study is consistent with these criteria is discussed below.

Design/premise

We employed a multiple case design -- (six distinct communities) and used multiple sources of evidence -- (statistical/ demographic reports, interviews with key informants, and focus groups). In addition, the study charted the evolution of each community's service system during the life of the project through at least two phases of data collection, documenting responses to emerging challenges (e.g., changing demographics, new health care crises,) and economic and political changes.

Both of our primary sources categorize and define a variety of applications for the case study method. Consistent with those definitions, the Promoting Success case study methodology can be defined as both "exploratory" and "explanatory." It is exploratory in that it asks the question, "What are the features of successful community efforts to serve families with young children?", examining the extent to which each community reflects the six criteria in our premise that were considered determinants and features of successful community based service systems. The premise was that the communities would demonstrate the following: 1) universal access to services; 2) linkages across a range of levels of care and service system needs; 3) commitment to family involvement in service planning and delivery; 4) state-level support and encouragement; 5) professional development opportunities for staff; and 6) inclusive/mainstreamed/non-categorical settings for services.

The case study is explanatory in that it attempts to determine how and why the community contexts shape the system of services in each community. For this case study, we used a broad definition of the term "community." It includes neighborhood, city, county or catchment area, and, as with similar studies, the community involved determined how it would be defined. The implications and consequences of this definition will be discussed below.

Data collection

Selection of communities

The data collection for the case study began with the selection of the participating communities. Project staff contacted a cross-section of professionals and national organizations with an interest in child health, health care and prevention services, as well as parent networks related to children with special needs. We asked for recommendations of communities that "utilize community-wide prevention strategies with high risk populations and facilitate linkages between early identification and services for infants/toddlers and their families." Our search for these communities was based on our broad definition, which could include neighborhood, city, county, or catchment area. It was anticipated that the ultimate selection would include communities that differed in terms of geographic boundaries, served different populations, were at different stages of development, and used different approaches. They were not to be defined as "successful models," but rather as communities which had attributes and approaches to service delivery that could be emulated.

From the more than 100 recommended communities, the review team selected 23 that demonstrated some of the desired features to invite to apply for participation in the project. Communities that chose to apply provided background information which documented existence of the six criteria we had identified as indicators of a comprehensive, family-oriented service system. The selection committee (which included project staff and advisors) rated and ranked the communities on their ability to demonstrate these indicators. The committee also sought representation of geographic and cultural diversity in the study, as well as a cross-section of service delivery approaches. Ultimately, six communities were selected.

Community liaisons

Our entree to the communities was facilitated by **liaison contacts**, individuals who were associated with a multi-service agency or coordinating body in each community and who had been identified during the nomination process. These individuals and their agencies were recognized as the primary coordinators of early intervention and family support service providers in their community. They also were acknowledged as the key facilitators, on behalf of families with infants/toddlers, of family access to the larger system of services (health, social services, child care). During the course of the study, the liaisons served as primary sources of information for the early childhood system of services, provided or coordinated the collection of demographic and statistical data, facilitated contact with all interviewees at the state and community levels, identified parent focus group participants and served as primary reviewer of all drafts of the communities descriptions.

Initial site visits

Within three months following selection, a site visit was made to each community by a team that included project staff and members of the project advisory committee. Team members met with representatives of state agencies involved with infant/toddler services, representatives of public and private provider agencies in the community, and parents in order to obtain an orientation to the community's service system.

Data collection instruments

Following the orientation site visits, project staff (with guidance from the advisory panel) began to implement for each community a more structured data collection process. This process included the design and testing of questionnaires to collect both demographic data and descriptive data on all components of the service system and preparation to conduct on-site structured interviews of key community representatives. In soliciting communities' to participate in the project, staff made its own commitment to present all requests for information in a format that would not place undue burden on the community liaisons. (This agreement was based, in part, on the fact that the project was not able to fund any extraordinary efforts on the part of community participants.) Therefore, the questionnaires to collect statistical and descriptive data were designed to be used by community liaisons to obtain critical information through sources that were readily available to them. We developed forms that would allow recording of:

- data on the demographic profile and the social/economic climate of the community;
- a comparison of community and state statistics on selected indicators; and
- sources of funding.

We also developed service system profile charts on which community liaisons could check off, for each service component in the community, the existence of variables/characteristics generally associated with quality service systems.

The interview questionnaire, while extensive, was designed to be used as a guide to ensure that critical information was not overlooked, rather than to be followed page by page by the interviewer. It includes questions that explore the history, goals, objectives, anticipated outcomes and other key aspects of the community's service system. All data collection instruments were reviewed by the community liaisons for ease of use prior to actual application. The forms and service system profile charts were mailed to the communities for completion and return. These completed forms and charts provided background information that could be reviewed by project staff prior to the visits.

Community site visits: Phase One

Project staff collected the balance of the case study data through a series of interviews in each community that were conducted during two phases of site visits. The first phase of site visits occurred in 1991 and included interviews with community liaisons, staff of selected provider agencies, parents, and at least one other individual who had some knowledge of the community service system. The basic interview guide was modified for each type of respondent (parent, community liaison, staff or community representative), but all respondents were asked the same categories of questions. Questionnaires were mailed to all respondents prior to the site visits to allow sufficient opportunity for reflection on the questions. In addition to questions related to the six criteria, the following types of questions were explored through open-ended discussion.

History: What was the process that helped the community to come to its comprehensive approach? How did the need for your interagency efforts arise? What cultural values influenced the design of the service system and the expected outcomes? Where was the interest and how has it changed? How much encouragement has there been from the state? How much from local people? What has been the effect of state support?

Point of focus: What do you see as the focus of your efforts? What are your intended outcomes? How do you show that you achieved them? Has this changed over time? Have there been any unexpected outcomes so far?

Preventive Approaches: Where do you see yourselves in terms of the criteria we described in our call for "model" community-wide prevention? What is provided to every family in your community? What is done to make your approach as universal as possible, to reach the hard-to-reach, etc.? How do you help families make use of

non-specialized services, such as child care, recreation, etc.? In what ways are health, education, social services, mental health, nutrition, etc., working together? What opportunities are there for staff to be supported in their work to foster knowledge, share information and prevent burnout? How are parents involved in advisory capacities? Are they involved in the decision-making roles for planning and evaluating services?

Evaluation Process: Why do you do what you do, in the way that you do it? Have you used approaches that have shaped your planning? Where do you see yourselves heading? What kinds of informal as well as formal evaluation strategies have you used to appraise your program's effectiveness or use as a planning tool? Each on-site interview lasted 2 to 3 hours.

Data review, analysis and preliminary report

Material collected during the 1991 phase of data collection (raw interview notes and supporting documents provided before, during and after site visits) was organized by the staff person who conducted the site visit into a draft comprehensive description of each community and its system of services. The community descriptions, developed in accordance with a pre-existing outline, contain statistical profiles, narrative description and chart presentation of the components of the service system (called service system profiles). Each community service system was then analyzed from the perspective of the six criteria in our hypothesis.

The review and analysis occurred in several stages. An initial review by project staff included regular telephone contact with community liaisons for clarification as necessary. Often additional or clarifying data were requested and provided, when available. Revised drafts were reviewed and analyzed in meetings with the advisory panel and mailed to community liaisons for review by key community representatives and providers.

At the project mid-point, in 1992, project staff and advisory committee and community liaisons concurred that the issues that had emerged thus far, as lessons learned, should be developed into a Preliminary Report to be shared with a selected audience. Using discussion guides developed for that purpose, community liaisons were brought together to discuss lessons learned.

A draft report was developed by project staff to focus specifically on a summary of lessons learned by all communities using examples from selected communities, as appropriate. The draft report was sent to community liaisons for a preliminary review and then reviewed and analyzed in a joint meeting of community liaisons and the advisory panel. Following that meeting, a revised report was mailed to each person interviewed with a request that they review for accuracy. Final revisions were made on the basis of those comments and the report, *Promoting Success in Zero to Three Services: A Case Study of Six Community Service Systems -- Preliminary Report*, was published in February, 1993. The report was widely disseminated to early childhood leaders, federal policy makers, and key individuals in the states that participated in the study. Reaction to the report from early childhood

leaders and state agency staff in the six states confirmed the case study findings. State and federal policy makers in particular expressed interest in seeing the Final Report address how supports could be provided to sustain successful community-based efforts.

Community site visits -- Phase Two

The next round of data collection site visits occurred during 1993, approximately two years after the second site visit to each community. The analysis of findings from our earlier site visits indicated a need for more contact with parents, more information from key early childhood providers who were not linked to the early intervention system, and more data on the state's role in supporting community-based services integration. Therefore, data collection for phase two focused on key community representatives and providers not included in the first round of interviews, such as Head Start providers, key state-level representatives, and a parent focus group in each community.

Again, a basic interview guide was used in which all respondents were asked the same categories of questions, with questions modified for each type of respondent (community liaison, community level provider or state-level representative). State-level interviewees included representatives from Governor's offices, State legislators, and state agency administrators. A special discussion guide was developed for the parent focus groups. (A sample follows this narrative). Questionnaires were mailed to all respondents prior to the site visits to allow sufficient opportunity for reflection on the questions. The interviews were supplemented with copies of reports and other documents provided by interviewees.

Analysis and final report

During the course of the Phase Two site visits, community participants and the case study team recognized that the six service system attributes or service integration strategies that had been used as criteria for selecting communities to participate in the study were not necessarily remaining as the focus of community activity or concern. What did emerge was a set of issues that community representatives found themselves confronting in their efforts to achieve initial and enduring success in community-based services integration. These issues are:

1. the importance of a common set of values and expectations concerning services integration among national state-level and community-level stakeholders;

2. the complexity of systems development at the community level;

3. the need to improve access to the data required to plan and evaluate community-level services integration; and

4. the role of leadership and support, at national, state, and local levels, for communities' efforts to develop integrated systems of services.

These issues were emerging as critical for the communities at the same time interest and support for services integration were increasing at the national level in Congress, federal agencies and private foundations. The case study team reasoned that the goal of the project (identifying and promoting services integration strategies that work at the community level and identifying the supports necessary to sustain successful efforts) could best be achieved by an analysis of these critical issues in the final report. Therefore, the design for the final report was revised to include an analysis of these issues and recommendations based on the analysis. Drafts of the final report were reviewed by community liaisons, state interviewees, the advisory panel, and MCHB staff.

COMMUNITY CASE STUDY ISSUES

At the time of the Promoting Success case study we were unable to identify any similar case study of community-based efforts that had followed the evolution of a community as it developed a system of services for a target population. Lacking a precedent for our undertaking, the case study team expected to encounter some challenges to achieving its objectives. These methodological challenges and what the team learned from them may warrant attention not only by investigators seeking to apply the case study method but also by policy makers, state-level planners, and community service providers who are committed to supporting communities in the provision of preventive, family-oriented services.

Issues that have emerged as salient for application of the case study method to communities include:

1. the definition of "community" and "service system";
2. collecting data at several points in time;
3. accessibility of statistical data; and
4. feasibility of outcome analysis.

Definitional issues

For this case study, we defined community broadly, to include neighborhood, city, county or catchment area. As has been done in similar studies, each community involved determined how its boundaries would be defined. Our review of the published literature and other documents most relevant for our purposes (Chamberlain, Hazel, Bureau of Maternal and Child Health, CCDP studies [see Bibliography for complete citations]) revealed a tendency among other investigators to avoid precise definitions of "community" and "service system." Instead, authors tend to describe a system of services that appears to be experiencing some success or that is attempting some innovative strategies. For the author, the geographic area or persons served by this system becomes "the community" and geographic location or boundaries, political designation, or socio-economic characteristics are used to distinguish the community under study from another.

From the beginning of the Promoting Success in Zero to Three Services study, we anticipated that the project communities would differ in terms of geographic boundaries, population densities, and demographic characteristics of populations

served. These differences were inevitable, given the flexible definition of community, and the deliberate selection of communities with diverse demographic profiles. We also anticipated differing definitions of a "system" of services. In some communities the system is a network of child health and health-oriented (e.g., WIC/EPSDT, P.T./O.T./speech) intervention programs. In others, the system includes various types of services that are available to children of various ages and family members. We found that each community's service system was as unique as the community itself. In some cases, the system was organized by representatives of a group of local programs, organizations, and local and state agencies who collaborated to develop a system. In other cases, a single program or facility serves as the central provider as well as the coordinator of other services in the community for infants/toddlers and their families. In each case, the community configuration and the service system configuration shape the information that is collected, its accessibility, and the possibilities for analysis of data across communities.

Repeated data collection

The methodology called for collection of data at least twice during the life of the project in order to document how communities and their service systems respond to potential economic, political and demographic changes. As communities experienced these changes at different times and degrees of intensity, we were faced with the challenge of describing and analyzing "moving targets." Each round of data collection focused on a specific point in time, but also documented and interpreted the changes that had occurred in the service system during the interim. The final report describes the evolution of each community from the beginning of the project and the trends that have occurred over time. Even after the last set of site visits occurred and the report was being written, the systems have continued to evolve, programs and services come and go, and in a few programs, service policies have changed.

Accessibility of statistical data

We had anticipated some problems in accessing statistical data. We did not realize how difficult, and sometimes impossible, it would be, in all of the project communities, to obtain data on the birth-to-three population that we needed in order to describe and analyze service systems. We learned that data about, for example, Medicaid utilization, may be aggregated for a state but not for a "community" as defined in this study. The community representatives agree with us that these are important data for both evaluating their service systems and for planning purposes. However, in most of the communities, obtaining the statistical data that do exist has been a very labor-intensive undertaking. In addition, in the cases where a single program or facility serves as the central provider as well as the coordinator of other services in the community for infants/toddlers, accessing data for the system as a whole was virtually impossible. This was particularly true of data on quality attributes and funding.

Our attempts to use the state as a resource for community data produced mixed results. Even state agency staff who had expressed a desire for specific data on

things like the cost of services for children in the study communities in their state were unsuccessful in assisting community-level staff to access the data needed to provide that information.

As a result of their participation in our project, community representatives have become more aware of the importance of, as well as the difficulties involved in, accessing statistical and descriptive data on service components in their service system.

Outcome analysis

Although the case study was not intended as an evaluation effort, we expected to learn about and discuss outcomes that the communities themselves expected to result from services integration. The analysis was to include an examination of how values/behavior unique to the community shaped expected outcomes and influenced the development of the service system. In most communities, we were able to get descriptions of purpose and mission statements from annual reports of the core service providers (Kids Place, CEDEN) but little data on how planners/designers of the larger system had articulated expected outcomes of the service system.

Moreover, while the interview was the technique of choice for developing the history of the service system, it proved problematic as a way to garner clear statements of expected outcomes. Almost all key community stakeholders could describe a vision of the services that should be provided and the needs that should be met through a service system, but most could not give a concrete statement of specific and measurable expected outcomes. Two complementary factors may explain this phenomenon. First, a focus on systemic outcomes may be difficult for collaborators to maintain when each component of the system has its own goals, practices, and administrative requirements. Second, since communities' service systems evolved by adding agencies over time, there does not appear to have been a point at which participants established a specific statement or list of system-wide expected outcomes. If the field is to apply the case study approach to established community systems for purposes of evaluating what "works" (i.e., achieves a planned outcome) and why it works, this issue is worthy of further study.

MCH National Resource Center for Children with Special Health Care Needs (Grant No. MCJ-115041)

Interview Guide

The following are a sample of topics that were addressed during our on site interviews. Project staff found the "guided interview" to be more productive than a straight question and answer session.

Community Liaisons

1. How would you say your community defines the following terms:
   - Universal access?
   - Case manager (roles, relationship to system of services, professional identify, other)?
   - Prevention and prevention services?

2. Re: Prevention services:
   - What were your original goals and strategies?
   - How and why have strategies changed?
   - What strategies for linkages and collaboration have proven effective for enhancing prevention services?
   - Give some examples of the erosion of prevention services?
   - Which services are most vulnerable?
   - What do these services cost? What percentage of your budget do they represent?
   - How is success defined?

3. Describe your agency's relationship with the following programs or services:
   - WIC nutritional services
   - Child protective services
   - Community-based child care services

4. Can you describe your agency's linkages with health care providers?
   - Who they are; how the linkages were formed; how they work;
   - Innovative and successful strategies for helping families to access health care services;
   - How your strategies for use of Medicaid and private insurers are factors in your success;
   - What do you see as specific barriers to family access to health services? Discuss financial and non-financial barriers.

5. Can you give an example of how your program/agency collaborates with another to coordinate services for a family? What are the policies and practices that apply?

6. Which strategies have you found to be most effective for enhancing linkages among agencies that serve families with your children?

7. Has your agency encountered federal or state-level policies or administrative requirements that obstructed service provision to families? Can you give specific examples that identify that specific federal or state programs? Describe the family situations and the outcome?

8. Are you aware of any state initiatives to enhance family access to health services? If yes, what has been the impact at your community level?

9. Your state is/was a participant in the Council of Governors Policy Advisors Family Academy. What has been the impact of this initiative at the community level?

10. From the perspective of your agency, which are the most effective linkages and collaborations among programs and agencies at the state-level?

11. Can you give specific examples of state agencies providing consultation or technical assistance to specific agencies or the system as a whole on issues of collaboration or linkages? If yes, was it effective?

12. Can you give examples of incentives provided by a state agency to support and reinforce the successes of an agency, program, or system of services?

13. Have there been social, political or economic changes in your state that have had an impact (positive or negative) on the way services are provided to families with young children in your community? Give specific examples. What was the response at the state-level? At the community level?

14. Can you cite specific issues that reflect major transitions over the past 3-4 years in the way services are organized or provided in your community? What are the priorities now as compared to 4-5 years ago? Are there different key players? Is there a difference in the population served?

15. What do you see as 3-5 most important things that state agencies can do to support family-oriented comprehensive systems of services at the community level?

Community Service Providers

1. How would you say your community defines the following terms:
   - Universal access?
   - Case manager (roles, relationship to the system of services, professional identity, other)?
   - Prevention and prevention services?

2. Who are the primary funders of your agency/program?

3. What are your relations to private funders (e.g., foundations, etc.)?

4. Of the services that your agency/program provides to families with young children, are there any that you would describe as prevention-oriented? How are they funded?

5. Describe your agency's relationship with the following programs or services:
   - WIC nutritional services
   - Child protective services
   - Community-based child care services

6. Can you describe your agency's linkages with health care providers?
   - Who they are; how the linkages were formed; how they work;
   - Innovative and successful strategies for helping families to access health care services;
   - How your strategies for use of Medicaid and private insurers are factors in your success;
   - What do you see as specific barriers to family access to health services? Discuss financial and non-financial barriers

7. What do you see as enhancers to collaboration and systems-building at the community level? As inhibitors?

8. Can you give an example of how your program/agency collaborates with another to coordinate services for a family? What are the policies and practices that apply?

9. Which strategies have you found to be most effective for enhancing linkages among agencies that serve families with young children?

10. Has your agency encountered federal or state-level policies or administrative requirements that obstructed service provision to families? Can you give specific examples that identify the specific federal or state programs? Describe the family situations and the outcome?

11. Are you aware of any state initiatives to enhance family access to health services? If yes, what has been the impact at your community level?

12. Your state is/was a participant in the Council of Governors' Policy Advisors Family Academy. What has been the impact of this initiative at the community level?

13. From the perspective of your agency, which are the most effective linkages and collaborations among programs and agencies at the state-level?

14. Can you give specific examples of state agencies providing consultation or technical assistance to specific agencies or the system as a whole on issues of collaboration or linkages? If yes, was it effective?

15. Can you give examples of incentives provided by a state agency to support and reinforce the successes of an agency, program, or system of services?

16. Have there been social, political or economic changes in your state that have had an impact (positive or negative) on the way services are provided to families with young children in your community? Give specific examples. What was the response at the state-level? At the community level?

17. Can you cite specific issues that reflect major transitions over the past 3-4 years in the way services are organized or provided in your community? What are the priorities now as compared to 4-5 years ago? Are there different key players? Is there a difference in the population served?

18. What do you see as 3-5 most important things that state agencies can do to support family-oriented comprehensive systems of services at the community level?

Parents

1. Describe how community resources are used to encourage or support parent involvement.

2. What are some strategies that have been employed to improve parent access to participating in parent oriented activities? Probing examples: central geographical location; flexible hours of service; accessible to public transportation; transportation provided for the disabled; transportation universally provided; bilingual staff (including those for hearing impaired); wheelchair accessible; waiting lists monitored and updated; other. Of those listed which have been most productive and what were the results? What strategies targeted fathers in particular and what were the results?

3. What types of parent training are most widely provided? Discuss % of parents who participated and the average # of training hours per participant.

4. To what extent have parents been used as trainers?

5. What opportunities exist for parents to become a part of the program or establish themselves in a career ladder track (e.g. operate child care homes; work as staff)?

6. What <u>percentage</u> of the following are parents:
   - Advisory committee (community wide)
   - Planning boards (community wide)
   - Staff in various programs community wide
   - Evaluators of specific programs and/or community wide service system
   - Decision makers regarding interagency agreements, budget development, program changes?

7. What remains as the major challenge/barrier to increase parent involvement in parent-oriented activities in the service system?

8. Are cultural values (ethnic, religious, economic) taken into account when services are provided? Do you feel that the service system is reaching all segments of the population in need of services? those most in need of services? If yes, to what extent do you attribute your success? If no, which groups are not being served? What do you see as the barriers to serving these groups? What strategies have been employed to address these barriers? What are the outcomes of your effort?

9. Does the religious community serve as a resource in the provision of services?

10. Which programs appear to have demonstrated the greatest success with parent involvement? Describe the types of parental involvement.

11. To what do they attribute their success?

12. What are some approaches provided for parent feedback on services provided?

13. Which programs have been less successful?

14. What do they identify as challenges/barriers?

15. What strategies have they employed to address these challenges?

16. What are the results of their efforts?

17. Do you think the current service system reflects the values of the families in the community?

18. Do mission statements, policies and procedures include a commitment to cultural inclusiveness and competency in service provision?

19. Are you aware of any strategies that have been applied system-wide to increase cultural and economic diversity:
    - Among recipients of services?
    - In staffing patterns?
    - In evaluation and planning bodies?

Case Managers

1. What is the size of the average caseload?

2. What are the training/experience backgrounds of the Case Managers you have encountered in the system? Types of disciplines represented.

3. Is there pre-service or in-service Training in Case Management? If yes: Adequate? Helpful?

4. Is supervision of the Case Manager adequate?

5. Describe the role of the Case Manager.

6. Do the system leadership and agency administration share the same perception of the role and functions as the Case Managers?

7. Is there adequate support for Case Managers from agency administration?

8. What are the most and least important functions of Case Managers as related to:
   - Working with families?
   - Working with other agencies?

9. Assessment of Case Management process in this system:
   - Major strengths
   - Major problems
   - Ways in which it can be improved

10. Describe the collaborative process among:
    - Agency administrators
    - Staff from various agencies
    - Case managers from various agencies

11. Which strategies are most productive for collaborative efforts?

12. As Case Managers work with the various agencies and providers within the system:
    - Do they have sufficient authority to access services needed from the various child-serving agencies?
    - How do they deal with conflict among agencies?

13. What are the protocols in the systems for initiating preventive services?

14. Which agencies are most effective at employing preventive strategies?

15. What barriers exist to working with families? Discuss system-wide and interagency barriers.

16. What attempts have been made to address these barriers? Which were most effective? Which did not work? Why?

17. Most significant service gaps

18. What should priorities be for improvement?

19. Major strengths of your service system.

State-Level Representatives

1. Are you familiar with the community that is participating in the Case Study? Is there another community in the state that is providing services to families with young children in a similar fashion?

2. Regarding the agencies/programs that are a part of the community system described--how are they organized at the state-level? How do they fit in the state government? How do they relate to each other? **(Is a chart available?)** Are there linkages between? Title V-MCH; Medicaid; WIC; Education-funded programs (such as Part H or Even Start-Family Literacy program); Child Welfare/Family Support programs; Child Care Programs (CCDBG & Title IV-A, At Risk Child Care); State-funded programs for young children?

3. Is there a linkage between these programs and Head Start and Head Start-related programs?

4. Can you give specific examples of collaboration/linkages or system building at the state-level?

5. What are some examples of positive outcomes at the local level from the collaboration that has occurred at the state-level?

6. Your state is/was a member of the Council of Governors' Policy Advisors Family Academy. How have policies regarding services for the birth to three population been influenced? How have services at the local level been affected? What do you expect the outcome to be?

7. What has been the impact of OBRA 1989 and 1990 on Medicaid utilization by the 0-3 population for the state: all 0-3; special needs 0-3?

8. Are there state initiatives to improve family access to 3rd party payers -- Medicaid and private insurance? How did these initiatives come into being?

9. Are there state initiatives to ensure family-orientation of managed care providers -- PPO'S and HMO'S? How did these initiatives originate?

10. Are there state initiatives to address the non-financial barriers to health care: geographic barriers; provider policies, (refusal to accept Medicaid, HMO's and PPO's limitations on services); provider practices?

11. What input do you get from parents regarding their priorities for their families and the state's role in helping them to address those priorities? What has been the response? What input do you get from parents regarding (an issue discussed in focus group)? What has been the response?

12. Can you give specific examples of state agency support (administrative or political), technical assistance, or incentives (fiscal or other) to communities to enhance linkages or system-building among agencies?

13. Have there been significant social/political/economic changes in your state in the last 2-3 years that have affected (positively or negatively) community-based services to families with young children? Specific examples of impact on services. How did the state respond?

14. What do you see as important issues for communities to consider in developing comprehensive systems of services for families with young children?

APPENDIX C: CASE STUDY INFORMANTS

COLORADO

Katherine Bair
Family Center Resource Coordinator
1401 Oak Creek Grade Road
Canon City, CO 81212

Lisa Barnard
Parent
1401 Washington #36
Canon City, CO 81212

Paula Birdsall
Parent
300 Rail Road
Rockvale, CO 81212

April Block
Supervisor, Early Childhood Services
Colorado Department of Education
201 E. Colfax
Denver, CO 80203

Helen Danahey, M.D.
Child & Adolescent Medicine
1335 Phay Avenue
Canon City, CO 81212

Shawnda Eppler
Parent
903 Chestnut
Canon City, CO 81212

Jill Fredrickson
Family Center Parent Coordinator
1620 Park Avenue
Canon City, CO 81212

Lois Grabowski
Head Start Education Coordinator
P.O. Box 510
Canon City, CO 81215

Misty Heiger
Parent
243 E. Douglas
Canon City, CO 81212

Marie Henderson
Family Center General Coordinator
1401 Oak Creek Grade Road
Canon City, CO 81212

Donna Holloway
Youth Services Supervisor III
P.O. Box 631
Canon City, CO 81215-0631

Mimi Howard, Director
Colorado's Parents As First Teachers
Office of the Governor
One Sherman Place, #100
140 East 19th Avenue
Denver, CO 80203

Denise Hyatt
Parent
132 1/2 West 7th
Florence, CO

Mary Elin Larson
Social Services Administrator IV
P.O. Box 631
Canon City, CO 81215-0631

Crystal Lee
Parent
2115 N 7th
Canon City, CO 81212

Ruby McCreight
Director
Head Start
P.O. Box 510
Canon City, CO 81215

April Munson
Parent
1026 Phay Avenue
Canon City, CO 81212

Mrs. Bea Romer
Chairperson
First Impressions
400 East 8th Avenue
Denver, CO 80203

Debbie Smith
Family Center Infant/Toddler
Coordinator
1401 Oak Creek Grade Road
Canon, CO 81212

Elizabeth Soper-Hepp, Supervisor
Early Childhood Services
Colorado Dept of Education-Part H
201 E. Colfax
Denver, CO 80203

Katherine Templeman
Parent
2605 E. Main
Canon City, CO 81212

Courtney Thomas
Director, Well Child EPSDT
Colorado Department of Health
4300 Cherry Creek Drive, South
Denver, CO 80222-1530

Pam Walker
Director, Project ECHO
101 North 14th Street
Canon City, CO 81212

Bonnie Waymire
Parent
807 Field
Canon City, CO 81212

Claudia Zundel
Family Center Coordinator
Office of the Governor
One Sherman Place #100
140 East 19th Avenue
Denver, CO 80203

ILLINOIS

Keena Bonds
Parent
1919 S. Sawyer, 1st Floor
Chicago, IL 60623

Kathy Caflisch
Local Office Administrator
Dept of Children & Family Services
3518 W. Division
Chicago, IL 60651

Tanya Carter
Parent
3422 W. Douglas
Chicago, IL 60623

Tiffany C. Coffee
Parent
1200 G. Central Park
Chicago, IL 60623

Diane DuBose
Parent
1328 S. Spaulding
Chicago, IL 60623

Edna Farmer
Parent
1913 South Lawndale, 2nd Floor
Chicago, IL 60623

Trawanda Harris
Parent
1518 S. Keeler
Chicago, IL 60623

Yvonne Heard
Parent
201 S. LaVergne, 2nd Floor
Chicago, IL 60644

Pam Jenkins, Program Director
Family Focus Lawndale
3600 W. Ogden Avenue
Chicago, IL 60623

Vivian Littles
Nursing Consultant
Chicago Department of Health
Room CL 88
500 W. Washington
Chicago, IL 60602

Karen Loeb
Assist to the Governor
for Special Projects
Office of the Governor
2 1/2 Capitol Building
Springfield, IL 62706

Kimberly Mallory
Parent
929 N. Latrobe
Chicago, IL 60651

Sherron Mullen
Parent
1818 South Millard, 1st Floor
Chicago, IL 60623

Maureen Patrick
Executive Director
Family Focus, Inc.
310 S. Peoria
Chicago, IL 60607-3520

Luis Rios
Supervisor
Fletcher Parent Child Center
3140 West Ogden Street
Chicago, IL 60623

Sandra Rogers
Parent
1321 S. Spaulding, 1-B
Chicago, IL 60623

Julia Rogers
Parent
3332 W. Polk
Chicago, IL 60624

Gilda Ferguson Smith
Executive Director
Family Focus Lawndale
3600 W. Ogden Avenue
Chicago, IL 60623

Jewel Snead
Project Director
Family Focus Lawndale
3600 W. Ogden Avenue
Chicago, IL 60623

Jerry Umanos, M.D.
Medical Director
Lawndale Christian Health Center
3860 West Ogden Avenue
Chicago, IL 60623

Julie B. Voetberg
Health Educator
Lawndale Christian Health Center
3860 W. Ogden Avenue
Chicago, IL 60623

Audrey Witzman
Part H Coordinator
Illinois State Board of Education
100 N. First Street, S-100
Springfield, IL 62777-0001

INDIANA

Trina Boytx
Parent
RR #6
Scottsburg, IN 47170

Pat Brown
Supervisor
Scott Co. Division of Family &
Children's Services
Route 1
Scottsburg, IN 47170

Freda Caudill
Parent
RR #2
Lexington, IN 47138

Priscilla Coomer
Parent
East Oard, 3994 Spring Road
Deputy, IN 47230

Maureen Greer
Part H Coordinator
FIRST STEPS/
Div of Family & Chldrn
402 W. Washington St., Rm W386
Indianapolis, IN 46204

Brenda Hammond
Parent
RR2 Box 187C
Pekin, IN 47165

Carolyn King
Associate Director
New Hope Services Center
725 Wall Street
Jeffersonville, IN 47130

Melissa Lee
Parent
475 N. Second Street
Scottsburg, IN 47170

Debbie Meyers
Head Start Director
OVO Head Start
P.O. Box 413
Madison, IN 47250

Ronald Murphy
Administrator
Scott County Health Department
Route 3, Box 9 B
Scottsburg, IN 47170

Marla Plummer
Parent
35 N Beechwood Avenue
Scottsburg, IN 47170

Paul Roahrig, Ph.D.
Executive Director
Special Services Unit
P.O. Box 846
Madison, IN 47250

Jean Robbins
WIC Coordinator
Kids Place
Route 3, Box 9
Scottsburg, IN 47170

Suzette Smith
Parent
245 S. 3rd Street
Austin, IN 47102

Janie Spencer
Parent
16 Scottvilla Trail Court
Scottsburg, IN 47170

Catherine Terrell, MSW, LCSW
Social Worker
Kids Place
Route 3, Box 9
Scottsburg, IN 47170

Rosann White
Parent
61 North Street
Austin, IN 47102

RHODE ISLAND

Sue Duggan Ball
Parent
890 Hopkins Hill Road
W. Greenwich, RI 02817

Bill Bryan
Parent
485 Weaver Hill Road
W. Green, RI 02817

Peter Dennehy
Principal Policy Analyst
Governor's Office
State House - Room 128
Providence, RI 02908

Arlene Dion
Coordinator
Parent and Child Center
848 Atwood Avenue
Cranston, RI 02920

Henry and Pam Goes
Parents
230 Cumberland Road
Warwick, RI 02888

Nancy Heroux
Director
John Ferris Health Center
821 West Shore Road
Warwick, RI 02889

Nancy Herrington
Program Monitor
State Dept of Children
Youth & Families
610 Mt. Pleasant Avenue, Bldg #1
Providence, RI 02908

Liz Killian
Parent
74 Claypool Drive
Warwick, RI 02886

Mary Legacy
Head Start, Director
848 Atwood Avenue
Cranston, RI 02920

Steve and Janet McAustin
Parents
28 Barre Court
Warwick, RI 02886

Diane Minich, Coordinator
Adolescent Parenting Program
Kent County Mental Health
1285A South County Trail
East Greenwich, RI 02816

Nancy Roberts
Assistant Director
Kent County VNA
51 Health Lane
Warwick, RI 02886

Ruth Schennum
Health Policy Analyst
Rhode Island Department of Health
3 Capital Hill
Providence, RI 02908-5097

Katie Smith
Parent
50 Patience Court
Warwick, RI 02888

Tracey Whirty-Maron
Consultant
Kent County VNA
Central Region Early Intervention
250 Commonwealth Avenue
Warwick, RI 02886

TEXAS

Senator Goazalo Barrientos
State Representative
P.O. Box 12068
Austin, TX 78767

Sharon Boatman
John H. Winters Human Services Center
701 West 51st Street
P.O. Box 149030
Austin, TX 78714-9030

Verna Browning
Deputy Director
Travis County Health and Human Services
P.O. Box 1748
Austin, TX 78767

Frances Cavanaugh
Parent
2304 Perry Avenue, #101
Austin, TX 78704

Gwen D. Chance, Director
Texas Health & Human Services Commission
4807 Spicewood Springs Road,
Bldg. 4 (78759), P.O. Box 13247
Austin, TX 78711

Gloria Cruz
Parent
5516 Icon Street
Austin, TX 78744

Gary Allen Cunningham
Parent
1300 Parker Lane, #209
Casa Loma Apartments
Austin, TX 78741

Michelle Dominguez
Parent
6109 Carnation Terrace
Austin, TX 78741

Beverly Duffee
Child Care Program Specialist
Texas Dept of Human Services
P.O. Box 149030, E-311
Austin, TX 78714-9030

John E. Evans
Chief, Bureau of Chronically Ill & Disabled Children Services
Texas Dept of Health
1100 West 49th Street
Austin, TX 78736-3179

Lisa Fabian
Parent
6410 A Wilcab Road
Austin, TX 78721

Gracie Gonzalesz
Parent
2212 Perry, #104
Austin, TX 78704

Patricia Goodyear
Child Health Nurse Consultant
Bureau of Maternal and Child Health
1100 West 49th Street
Austin, TX 78756-3199

Sally Hamilton
Case Manager
Pride Program
P.O. Box 430
Austin, TX 78702-0430

Susan Johnson
Director of Program Planning
Governor's Office
Health and Human Services
P.O. Box 12428
Austin, TX 78711

Rubina Mendez
Parent
2989 E. 51st, #105
Austin, TX 78723

Paula & Ernest Murillo
Parents
3106 Bessie Avenue
Del Valle, TX 78617

Glenda Overfelt
Community Coordination Specialist
Child, Inc.
818 E. 53rd
Austin, TX 78751

Suzy Plyler
Director
Kiddie City Child Care
1203 E. 7th Street
Austin, TX 78702

Juanita Rayo
Parent
2605 Diaz
Austin, TX 78702

Walter Rostow
Chairman
The Austin Project
LBJ Library
2313 Red River
Austin, TX 78705

Donna Samuelson
Assistant Executive Director
Early Childhood Intervention
1100 W. 49th Street
Austin, TX 78756-3199

Marian Sokol, Ph.D.
Executive Director
Any Baby Can
5410 Fredericksburg Road
Suite 104
San Antonio, TX 78229

James Strickland
Executive Director
Child, Inc.
818 E. 53rd
Austin, TX 78702

Emily Vargas-Adams, Ph.D.
Executive Director
CEDEN Family Resource Center
1208 E. 7th Street
Austin, TX 78702

Ann Vetters
Child Health Program Coordinator
City of Austin
603 E. Liberty
Round Rock, TX 78664

Linda Welsh, M.A.
Coordinator, Early Childhood Development
Health & Human Services Department
City of Austin
P.O. Box 1088
Austin, TX 78767

WASHINGTON

Pat Barnhart
Area Manager
DCFS/DSHS
840 N. Broadway, Building A
Everett, WA 98201

Terry Clark
Family Development Director
Olympic Mental Health
4526 Federal Avenue
Everett, WA 98203

Dana Connolly
Executive Director
HEAD START
134th Street, SW #A-5
Everett, WA 98043

Faye & Ray Fletcher
Parents
920 104th Place, S.E.
Everett, WA 98208

Kathleen & Keith Harrell
Parents
1607 Virginia Avenue
Everett, WA 98201

Maxine Hayes, M.D., MTH
Asst Sec for Parent-Child Hlth Srvc
State of WA Dept of Health
Airdustrial Park, Building 7,
P.O. Box 47880
Olympia, WA 98504

Leslie Carroll & Carey Jackson
Parents
14610 62nd Drive, SE
Everett, WA 98208

Sandy Loerch
Director
Birth To Six State Planning Project
P.O. Box 45201
Olympia, WA 98504-5201

Carrie & Greg Masten
Parents
722 55th Street, SW Unit A
Everett, WA 98203

Laurie & Mathew McBryde
Parents
5719 202nd Street, SW #12
Lynnwood, WA 98036

Shannon & Terry McCord
Parents
805 Laurel Drive
Everett, WA 98201

Liz & Mark Patterson
Parents
530 150th Place, SW
Lynnwood, WA 98037

Jean Sittauer
Parent
9220 192nd Place, SW
Edmonds, WA 98020

Carol Strandley
Maternal Child Health Supervisor
Snohomish Health District
3020 Rucker Avenue, Suite 200
Everett, WA 98201

Mary & James Tremayne
Parents
225 109th Place, SE
Everett, WA 98208

Ginny Ware, Director
Providence Hospital Children's Center
P.O. Box 1067
Everett, WA 98206

Colleen Wartelle, Program Manager
Little Red School House, Inc.
3210 200th Place, SW
Lynnwood, WA 98046

Kay & Ray Wheeler
Parents
11504 62nd Avenue, West
Lynnwood, WA 98037